

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7062

07049

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CLINTON c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SOUTHERN MD. HOSPITAL CENTER				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY P. GEO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON d. STREET ADDRESS ST. JOHN'S RECTORY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) ANNA ATKINSON		4. DATE OF DEATH Month JUNE Day 3 Year 1961		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR-13-1909		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER				10b. KIND OF BUSINESS OR INDUSTRY RECTORY				11. BIRTHPLACE (County & State, or foreign country) N.Y.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward P. Finn				14. MOTHER'S MAIDEN NAME Ella Williams				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 1213-294-874				17. INFORMANT SON Address ROBERT ATKINSON 1213-294-874 WASH. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (b) HYPERTENSIVE CARDIOVASCULAR DISEASE (c) 30 yrs. DUE TO 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERSEPTAL MYOCARDIAL INFARCTION, SUBACUTE-HEART BLOCK 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE																			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE																			
20c. TIME OF INJURY Month, Day, Year NONE				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> NONE				20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) NONE				20f. (City or town) (County) (State) NONE							
21. I certify that (I) (this hospital) attended the deceased from MARCH 1960 to PRES. 1961 and that death occurred at 145 from the causes and on the date stated above.																			
22a. SIGNATURE Arthur Shaver Jr. M.D.										22b. DATE SIGNED 6/3/61				22c. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. BRANCH AVE. - CLINTON, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 6-61				23b. DATE THEREOF June 6-61				23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln				23d. LOCATION (City, town or county) (State) Bladesburg Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Samuel Buss ADDRESS 1661 9th Ave Rd SE Wash DC										25a. REC'D BY REGISTRAR DATE JUN 5 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Evans					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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PRINCE GEORGE

WINDWARD

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GLANTON

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GLANTON

SOUTHERN NO. WESTERN CENTER ST. JAMES KENTUCKY

ALMA

WINDWARD

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The law requires that the death certificate be completed within 24 hours after the death. The law also requires that the death certificate be completed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7063 Items 8 & 9 Film G286 6/15/61 iwk 07050

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN b. 12 days		d. STREET ADDRESS 3516 Madison Place	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AKA - Otto H. Graeser William A. Baesler		4. DATE OF DEATH June 7 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-1888 1883 7879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor		10b. KIND OF BUSINESS OR INDUSTRY Diamond Cab Co	
11. BIRTHPLACE (County & State, or foreign country) Pa or New Jersey ?		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-24-4642	
17. INFORMANT Louis E. McConnell		Address Hyattsville, Md. 3516 Madison Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-1 DUE TO Coronary occlusion (b) Congestive heart failure and (c) Altherosclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 hr 2 hr 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1954, to June 7, 1961, that (I) (we) last saw the deceased alive on June 7, 1961, and that death occurred at 9:45 A.M. The causes and on the date stated above.			
22a. SIGNATURE John Kehoe		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. John Kehoe		22d. ADDRESS 6300 Riverdale Road	
22e. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-10-1961	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Prince George Co Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. G. Mattingly		24a. REC'D BY REGISTRAR 12 1961	
24b. ADDRESS 131-17th St. S.E.		24c. REGISTRAR'S SIGNATURE	

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1391-01

TO WIT: I, the undersigned, being a duly qualified physician, do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State Department of Health.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7064											
CERTIFICATE OF DEATH											
07051											
1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Powder Mill</u> c. LENGTH OF STAY IN <u>1 Month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Deland Memorial</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Cuyahoga</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cleveland</u> d. STREET ADDRESS <u>3726 - W 47th St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>SARAH ANN BAILEY</u>						4. DATE OF DEATH <u>JUNE 2 19 61</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/31/88</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Andrew Gregory</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>579-36-3315</u>					
17. INFORMANT <u>Mrs Gladys J. Krug</u>						Address <u>3726 W. 47th Place Cleveland Ohio</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>442X</u> DUE TO <u>Chronic Hemorrhoids - Refractory</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>2 Azotemia</u> <u>Anterose sclerotic cardio-vascular</u> <u>Renal Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 1961</u> to <u>June 61</u> ; that (I) (we) last saw the deceased alive on <u>June 1 1961</u> , and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>W.L. Etienne</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/2/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>						22d. ADDRESS <u>College Park Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6-5-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Bladensburg, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>						ADDRESS <u>5801 Cleveland Ave. Powder Mill, Md.</u>		25a. REC'D BY REGISTRAR <u>June 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

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FOR STATE
HEALTH DEPT.

NOTARY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7065

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07052

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince George's				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b D. E. A				d. STREET ADDRESS 1433 Spring Road N. W.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) David				4. DATE OF DEATH Month June Day 14 Year 19 61			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 21, 1929	
9. AGE (In years last birthday) 32		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Knoxville, Tenn	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Samuel Bethune				14. MOTHER'S MAIDEN NAME Ellen Washington			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 411-44-3906		17. INFORMANT Address Martha Ann Bethune, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY ATHEROSCLEROSIS, SEVERE (c) 420-1 DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 6/14/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-15-61		22c. NAME OF CEMETERY OR CREMATORY Flannagan & Parker Fun. Home		22d. LOCATION (City, town, or country) (State) Greenville, North Carolina	
23. FUNERAL DIRECTOR Allye L. Boyd Jr.				24a. REC'D BY REGISTRAR JUN 16 61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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Director of Columbia

Prince George's

Washington

Prince George's

1000 Spring Road, N.W.

Prince George's General Hospital

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General, 1000

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Colonel

General

Knoxville, Tenn

U. S. A.

William Washington

General Postman

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11-1-1900

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General Postman

General Postman

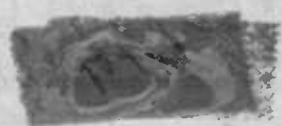
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James I. Boyd



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. The law requires that the death certificate be filed within 24 hours after death. The law requires that the death certificate be filed within 24 hours after death.

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VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7066											
CERTIFICATE OF DEATH											
07053											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY -					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)						c. LENGTH OF STAY IN 1b 6 months & 20 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital						d. STREET ADDRESS Washington 47X-3					
3. NAME OF DECEASED (Type or print) First Middle Last Mary Belle Boston						4. DATE OF DEATH Month Day Year 6 18 19 61					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/6/75		9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Government worker						11. BIRTHPLACE (County & State, or foreign country) Va. USA					
13. FATHER'S NAME Charles B. Boston						14. MOTHER'S MAIDEN NAME Elizabeth Garrett					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown						16. SOCIAL SECURITY NO. Unknown					
17. INFORMANT Decedent						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced											
DUE TO (b) 002X											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary fibrosis and emphysema; generalized arteriosclerosis with arteriosclerotic cardiovascular disease; rt., pneumothorax, re-expanded.											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 4/61											
21. I certify that (I) (this hospital) attended the deceased from 11/29/1960 to 6/18/61, that (I) (we) last saw the deceased alive on 6/18/1961, and that death occurred at p.m., from the causes and on the date stated above.											
22a. SIGNATURE Moe Weiss M.D.											
22b. DATE SIGNED 6/18/61											
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.											
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) burial											
23b. DATE THEREOF 6/21/61											
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery											
23d. LOCATION (City, town or county) (State) Pr. Geo. Co., Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The S.H. Hines Co, 2901-14th St NW											
25a. REC'D BY REGISTRAR DATE JUN 21 1961											
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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CERTIFICATE OF DEATH

Reg. Dist. No. 07054

7067

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 District Heights, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GEN. HOSP.</u>		d. STREET ADDRESS <u>7805 Atwood Street</u>	
3. NAME OF DECEASED (Type or print) <u>FORREST J. BOSWELL</u>		4. DATE OF DEATH <u>JUNE 20</u> 19 <u>61</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/60</u>
9. AGE (In years lost birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Boswell</u>		14. MOTHER'S MAIDEN NAME <u>Gwendolyn ATKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>JOSEPH L. BOSWELL SAME AS #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Respiratory Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchiolitis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 18</u> , 19 <u>61</u> , to <u>June 20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>61</u> , and that death occurred at <u>2:00</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Perkins</u>		ADDRESS (Street, city or town, state) <u>5301 Hamilton St., Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN W. PERKINS</u>		DATE SIGNED <u>6/21/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>6/23/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Southland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co - 517 N. 55th St. Wash D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 23 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinne</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077297XV4

1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07055

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Delaware b. COUNTY New Castle		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b Dead on arrival		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			e. STREET ADDRESS 710 Euclid Avenue		
3. NAME OF DECEASED (Type or print) ALBERT HENRY BOWERS			4. DATE OF DEATH Month June Day 8 Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1926		9. AGE (In years last birthday) yrs. 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Horse Transportation		11. BIRTHPLACE (State or foreign country) Delaware	
13. FATHER'S NAME Frank Bowers			14. MOTHER'S MAIDEN NAME Pearl Justus		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. 11 222-12-2716		17. INFORMANT Doris G. Bowers Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Crushed chest, large lacerations of perineum, multiple lacerations and abrasions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) over on him Driver of a truck that collided with another car and turned			
20c. TIME OF INJURY Month, Day, Year 12:30 am 6/ 8 19 61		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road Landover P. G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 8th., 1961	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/61		22c. NAME OF CEMETERY OR CREMATORY Lombardy Cemetery	
22d. LOCATION (City, town, or country) Rural Wilmington, Delaware		24a. REC'D BY REGISTRAR W.W. Chambers Esq Riverdale, Md.			
23. FUNERAL DIRECTOR W.W. Chambers Esq Riverdale, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

Page 101
101

14

1

07055

May 20, 1938

Bellevue

Police Station

Bellevue

Lead on subject

Subject

750 North Avenue

James George's General Store

John

John

John

30

May 21, 1938

White

Male

Bellevue

James' Transportation

Frank Taylor

Frank Taylor

Frank Taylor

Age 35

John G. Powers

222-12-276

W. J.

Age

Bellevue and area

Bellevue

Bellevue

Quoted as: a few variations of names, initials

variations and initials

Over at his

Review of a firm that collides with another car of same

10

Bellevue

Lead

X

at 3:00

10:00

June 22, 1938

James G. Powers

Bellevue

Lead on subject

6/22/38

Lead

James G. Powers

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7069

07056

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Newell Bowman				4. DATE OF DEATH June 6 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 Mar. 1901	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mech. Eng Retired		10b. KIND OF BUSINESS OR INDUSTRY Bu. Ships-U. S. Govt		11. BIRTHPLACE (County & State, or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bowman				14. MOTHER'S MAIDEN NAME Helen Ross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Patty M. Bowman-wife-Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTESTINAL OBSTRUCTION 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PERITONITIS DUE TO (c) Ruptured diverticulum Sigmoid							INTERVAL BETWEEN ONSET AND DEATH 36 hrs 48 hrs 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema of Lungs							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from June 6/6 , 19 61 to 6/6 , 19 61 , that (I) (we) last saw the deceased alive on 6/6 , 19 61 , and that death occurred 11:05 PM from the causes and on the date stated above.							
22a. SIGNATURE M. D. Comeau				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/7/61	
22c. PHYSICIAN'S NAME (Type) Dr. N. Comeau. M.D.				22d. ADDRESS Mt. Rainier., Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/1961		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) Rockville Maryland (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS J.B. Bethesda, Md.		25a. REC'D BY REGISTRAR JUN 8 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1993. 1000

John Bowman

Yours,

Bu. Shippe-U. S. Govt Colorado

1891\01\8

Praklaṇḍhaṇaṁ

CERTIFICATE OF DEATH

Reg. Dist. No.

07057

7070

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b Hyattsville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor, 4922 La Salle Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 3420 16th Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Brooks Last Brooks		4. DATE OF DEATH Month June Day 27 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-1886
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months 4 Days 7 Hours 15 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - -	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Mertz		14. MOTHER'S MAIDEN NAME Ida Israel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sr. M. Bernadete Joseph		Address 4922 La Salle Road, Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST C 170X DUE TO GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PATHOLOGICAL FRACTURE OF Femur DUE TO (c) Left 4 month PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAR , 19 61 , to JUNE 27 , 19 61 , that I last saw the deceased alive on June 27 , 19 61 , and that death occurred at 6:50 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 322 H AINE Wash DC DATE SIGNED 6-27-61 ACTUAL SIGNATURE Thomas F Collins M.D. 322 H AINE Wash DC PHYSICIAN'S NAME (Type) THOMAS F COLLINS 322 H AINE Wash DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-30-1961	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Inc. 1756 Pa Ave NW Wash DC		24a. REC'D BY REGISTRAR DATE JUN 30 '61	
24b. REGISTRAR'S SIGNATURE Carlton L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7071											
CERTIFICATE OF DEATH											
07058											
1. PLACE OF DEATH a. COUNTY Prince Georges						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 8111 51st. Ave.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b 27 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Rosa M. Brooks						4. DATE OF DEATH Month Day Year 6 4 19 61					
5. SEX F		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-89		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (County & State, or foreign country) Louisa County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown						14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Address George Brooks -son 8105 51st Avenue					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pul. edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Ht Dis. (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from May 9 , 19 61 to June 4 , 19 61 that (I) (we) last saw the deceased alive on June 4 , 19 61 and that death occurred 4:30 PM from the causes and on the date stated above.											
22a. SIGNATURE Max M. Herzberg						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. Max M. Herzberg			
22d. ADDRESS 7016 Greig Street, Seat Pleasant, Md.						22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) 6-9-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL				23d. LOCATION (City, town or county) (State) SUITLAND, MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE Arthur E. Kline						414-15th St, S.E.		25a. REC'D BY REGISTRAR DATE JUN 6 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Kline	

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7072

07053

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 21 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 3702 Oliver Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wade		First W.		Last Brooks		4. DATE OF DEATH Month 6/30 Day 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-06		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.	IF UNDER 24 HRS. Months 55 Days 55 Hours 55 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service station		10b. KIND OF BUSINESS OR INDUSTRY Attendant		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Brooks				14. MOTHER'S MAIDEN NAME Elizabeth Glass			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Willie Mae Brooks Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 585X DUE TO Box enema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bile Pentamites (c) Acute Cholelithiasis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Washington D C	(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 8:55 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Saul Schwartzback		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE June 30, 1961			
22c. PHYSICIAN'S NAME (Type) Saul Schwartzback		22d. ADDRESS Washington D C					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 7/1/61	23c. NAME OF CEMETERY OR CREMATORY Princeton		23d. LOCATION (City, town, or county) (State) West Va			
24. FUNERAL DIRECTOR'S SIGNATURE F. R. S. Sons Hyattsville Md				25a. REC'D BY REGISTRAR DATE JUL 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7052

CENTRAL BANK OF INDIA

07058

(M)

THE CENTRAL BANK OF INDIA
CALCUTTA
1947

TO THE
MANAGER
THE CENTRAL BANK OF INDIA
CALCUTTA

FROM
THE
MANAGER
THE CENTRAL BANK OF INDIA
CALCUTTA

SUBJECT: [illegible]

[Large block of illegible handwritten text, likely a letter or memorandum, covering the bottom half of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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7073
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
07060

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 30 Min d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md. d. STREET ADDRESS 5208 Upshur St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) THOMAS W. BYGATE		4. DATE OF DEATH Month Day Year JUNE 10, 1961		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 9, 1909		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days 52		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) International Co Operative U S Government				10b. KIND OF BUSINESS OR INDUSTRY Ohio				11. BIRTHPLACE (County & State, or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel R Bygate				14. MOTHER'S MAIDEN NAME Faye Smith				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no				17. INFORMANT Josephine Bygate Bladensburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hour												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bladensburg, Md.		(County) Prince George		(State) Md.							
21. I certify that (I) (this hospital) attended the deceased from MAY 19 1961 to JUNE 10 1961 , that (I) (we) last saw the deceased alive on JUNE 10, 1961 , and that death occurred at 6:15 PM from the causes and on the date stated above.																			
22a. SIGNATURE William D. Rosson M.D.				22b. DATE SIGNED 6/10/61				22c. PHYSICIAN'S NAME (Type) Dr. William D. Rosson, M.D.				22d. ADDRESS 5701 85th Ave., Cottage City, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 13, 1961		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City, town or county) Colmar Manor, Maryland.									
24. FUNERAL DIRECTOR'S SIGNATURE G. Gasch's Sons				ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JUN 12 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Hines							

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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7074

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07061

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bell's Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road			
f. STREET ADDRESS # 1 Thomas Court				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Marie Middle Chappell Last				4. DATE OF DEATH Month June Day 30, Year 1961			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1961		9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Topoka Kansas		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Otis Franklin Chappell, Jr				14. MOTHER'S MAIDEN NAME Constance Eleanor Faunce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Otis Franklin Chappell, Jr Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congenital heart disease & undernutrition 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hydrocephalus and multiple anomalies DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH birth on	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/22 19 61 , to 6/30 19 61 , that (I) (we) last saw the deceased alive on 6/30 19 61 , and that death occurred at 3 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas A. Christensen				22b. DATE 6/30/61		22c. PHYSICIAN'S NAME (Type) Thomas A Christensen	
22d. ADDRESS College Park Maryland				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. SIGNATURE Arthur L. Krand	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 1, 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				24a. ADDRESS Hyattsville, Md.		24b. REC'D BY REGISTRAR DATE JUL 3 '61	
24c. REGISTRAR'S SIGNATURE Arthur L. Krand				24d. ADDRESS College Park Maryland		24e. DATE JUL 3 '61	

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CERTIFICATE OF DEATH



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7075
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07062

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 23 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4813 Nicholson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Flora Middle Ann Last Cheek				4. DATE OF DEATH Month June Day 18 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Jan 1880		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MANASA ROBEY				14. MOTHER'S MAIDEN NAME SARAH E. COLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS GRACE SNIDER DAUGHTER Address 4516 37th ST BRENTWOOD, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and Hemorrhage 143X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Carcinoma of the floor of the mouth with metastases. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 15, 1961 to June 18, 1961 that (I) (we) last saw the deceased alive on 6/18, 1961 , and that death occurred on 2, 30AM from the causes and on the date stated above.							
22a. SIGNATURE Dr. Connor, M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. Connor, M.D.	
22d. ADDRESS 5813 Landover Road, Cheverly, Md.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-21-61		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wells Chambers Co.				25a. REC'D BY REGISTRAR JUN 21 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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7076

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07063

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jacqueline Churchill		4. DATE OF DEATH Month Day Year June 13 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 June 1961
9. AGE (In years last birthday) yrs. 16		10. IF UNDER 1 YEAR Months Days Hours Min. 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack Gibson Churchill Jr.		14. MOTHER'S MAIDEN NAME Mary Jane Conway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO <i>White mass</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Prematurity</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 4:00 PM from the causes and on the date stated above.			
22a. SIGNATURE <i>George Hageage</i>		22b. DATE SIGNED 6-15-61	
22c. PHYSICIAN'S NAME (Type) Dr. G. Hageage M.D.		22d. ADDRESS Mt. Rainier., Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 15, 1961	
23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington D C	
24. FUNERAL DIRECTOR'S SIGNATURE R. Gasch's Sons		25a. REC'D BY REGISTRAR JUN 19 61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles S. Finner</i>	

2077171XVI

STATEMENT OF DEATH
CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____
12. Place of registration: _____

CHIEF CLERK
REGISTERED

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TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
07064															
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY -										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)					c. LENGTH OF STAY IN 1b 7 months and 5 days										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital					d. STREET ADDRESS Washington 1111 Penn St., N.E. Apt. #1										
3. NAME OF DECEASED (Type or print) John Lee Coleman					4. DATE OF DEATH 6 12 19 61										
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3/5/21		9. AGE (In years last birthday) 40 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Counter clerk					10b. KIND OF BUSINESS OR INDUSTRY Marks Grocery		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME John Coleman					14. MOTHER'S MAIDEN NAME Daisy Dawson										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 1944 - 1945 578-16-0554		17. INFORMANT Decedent			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postoperative death, left pneumonectomy and right lobar pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis, active 21 yrs. 8 mo.; possible myocardial infarction										INTERVAL BETWEEN ONSET AND DEATH Operation 6/6/61					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/7/1960, to 6/12/1961 that (I) (we) last saw the deceased alive on 6/12/1961, and that death occurred at 8:10 P.M. from the causes and on the date stated above.										22a. SIGNATURE Moe Weiss, M. D.		22b. DATE SIGNED 6/12/61			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.					22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-16-61		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L			23d. LOCATION (City, town or county) (State) FT. MYER, VIRGINIA								
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Hanna					ADDRESS 414 15th S.E. D.C.		25a. REC'D BY REGISTRAR DATE JUN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna						

TO ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
7078 CERTIFICATE OF DEATH 07065													
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>							
c. LENGTH OF STAY IN 1b <u>12 days</u>						d. STREET ADDRESS <u>1710 S. Taylor St.</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>USAF Hospital Andrews</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>(Coleman) Thomas J Coleman</u>						4. DATE OF DEATH Month Day Year <u>June 9 1961</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>Can</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 APR 1917</u>		9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days			
										IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Computer operator-statistician</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>DAD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Boston, Mass</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>Patrick J. Coleman</u>						14. MOTHER'S MAIDEN NAME <u>Ellen C. O'Donnell</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>Yes</u> (If yes give war or dates of service) <u>-1959</u>						16. SOCIAL SECURITY NO. <u>010-03-478</u>						17. INFORMANT Address <u>1710 S. Taylor St</u> <u>Mrs. Renee Coleman Arlington Va</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Disease</u> (c) <u>Diabetes Mellitus and Hypertension</u> cause last.													
INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>2 yrs</u> <u>2 yrs -</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that the (this hospital) attended the deceased from <u>May 28</u> , 19 <u>61</u> , to <u>June 9</u> , 19 <u>61</u> , that we (we) last saw the deceased alive on <u>June 9</u> , 19 <u>61</u> , and that death occurred at <u>4:55</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Jay H. Poppe</u>						M.D. <input type="checkbox"/>		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>JAY H POPPELL, Captain USAF MC</u>						22d. ADDRESS <u>USAF Hospital Andrews, Wash DC</u>		22b. DATE SIGNED <u>June 9, 1961</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/13/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u>				23d. LOCATION (City, town or county) <u>Arlington</u> (State) <u>Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Fitzgerald Jew Home, Arlington, Va.</u>						ADDRESS <u>1710 S. Taylor St</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

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Rural - Prince Georges
12 days

WAF Hospital Andrews

(Colonel) Thomas J

M Com

Comptroller - Stephen DND

1st Lt J. Coleman

1st Lt J. Coleman

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Virginia

Washington

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
TITIAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7079

07066

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DERWOOD d. STREET ADDRESS 15X - 2					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b Dead on arrival d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Peter Harmon Cope				4. DATE OF DEATH Month Day Year June 6th., 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 20 1936			
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY CARNIVAL					
13. FATHER'S NAME HARMON CODE				14. MOTHER'S MAIDEN NAME MARTHA BELL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. YES					
17. INFORMANT KELLY COPE.				18. ADDRESS DERWOOD, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Fracture of base of skull DUE TO (c) 8-13X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of auto that ran off road and struck					
20c. TIME OF INJURY Month, Day, Year 3:45 p.m. 6-6-61				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road			
20f. (City or town) Upper Marlboro P.g. Co.				20g. (County) Prince George's					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE JAMES I. BOYD, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED June 6th., 1961					
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-9-61		22c. NAME OF CEMETERY OR CREMATORY Cope Cemetery		22d. LOCATION (City, town, or country) (State) Jonesville, Virginia			
23. FUNERAL DIRECTOR W.W. Chambers & Co				24a. REC'D BY REGISTRAR JUN 12 '61					
24b. REGISTRAR'S SIGNATURE Charles S. Thomas				DATE					

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Handwritten text, mostly illegible due to blurriness and bleed-through. Visible fragments include:

- Top left: "22088"
- Top center: "17th Street"
- Top right: "Prince George's"
- Middle left: "17th Street"
- Middle center: "17th Street"
- Middle right: "17th Street"
- Bottom left: "17th Street"
- Bottom center: "17th Street"
- Bottom right: "17th Street"

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7080

07067

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 74 Beltsville d. STREET ADDRESS 4401 Tonquil Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FANNIE A. COSTON		4. DATE OF DEATH Month June Day 22 Year 19 61	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 10, 1875
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jackson Aman	
14. MOTHER'S MAIDEN NAME Laura Aman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Medical Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured left femoral neck		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20. fell at home 6-7-61		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 22, 1961 to June 22, 1961 ; that (I) (we) last saw the deceased alive on June 22, 1961 , and that death occurred at 12 PM , from the causes and on the date stated above.			
22a. SIGNATURE Rowland Wilkinson		22b. DATE SIGNED June 22, 1961	
22c. PHYSICIAN'S NAME (Type) Rowland Wilkinson		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) transportation 6/23/61		23b. DATE THEREOF 6/23/61	
23c. NAME OF CEMETERY OR CREMATORY New Bern		23d. LOCATION (City, town or county) (State) North Carolina	
24 FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		25c. DATE JUN 26 '61	

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076

ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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70-6

07002

James Earl Ray
born 1928
442 10th Street
St. Louis, Mo.
June 17, 1928
Ray, James Earl
born 1928
442 10th Street
St. Louis, Mo.
June 17, 1928
Ray, James Earl
born 1928
442 10th Street
St. Louis, Mo.
June 17, 1928

1

James Earl Ray
born 1928
442 10th Street
St. Louis, Mo.
June 17, 1928
Ray, James Earl
born 1928
442 10th Street
St. Louis, Mo.
June 17, 1928
Ray, James Earl
born 1928
442 10th Street
St. Louis, Mo.
June 17, 1928

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Boyd notified by phone and agreed to certify cause of death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. d. STREET ADDRESS 226 9th St., N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Rachel		First		Middle		Last Crickard		4. DATE OF DEATH Month June 6 Day 19 Year 61	
5. SEX Female		6. COLOR OF RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1880		9. AGE (In years last birthday) 81 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Nattoway, Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Dunn				14. MOTHER'S NAME Mary Jane Franks					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Robert G. Crickard		Address 4852- Forestville Rd. S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 331 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Transition & Dehydration (a), stating the underlying cause last, DUE TO (c) C.V.A. Left sided Invaluable PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Coronary & Cerebral Artery Disease INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days 5 days									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Lived alone, fell down steps, lay unattended 3 days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Prob 6/2/61 p.m. am		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Wash (County) D.C. (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/4/61 19 61 to 6/6/61 19 61 , that (I) (we) last saw the deceased alive on 6/5/61 19 61 , and that death occurred at 11 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Kelvin L. Minchen				M.D. Dr. Kelvin Minchen, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/6/61	
22c. PHYSICIAN'S NAME (Type) Dr. Kelvin Minchen, M.D.				22d. ADDRESS 7200 Marlboro Pike, S.E. Washington, D.C. 28					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 9th 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) Suitland, Maryland (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros				ADDRESS 1661 GOOD HOPE WASH. 20, D.C.		25a. REC'D BY REGISTRAR JUN 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1981

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Prince George's County

Chesapeake

Prince George's County Hospital

Medical

General

Internal

Obstetrics

Emergency

Post & Burn

Emergency

Robert E. Grier, M.D. - Director

Dr. Robert E. Grier

Dr. Robert E. Grier

Dr. Robert E. Grier

Dr. Robert E. Grier

Dr. Robert E. Grier

Dr. Robert E. Grier

Dr. Robert E. Grier

Dr. Robert E. Grier

Dr. Robert E. Grier

Dr. Robert E. Grier

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

information from birth cert.

7082

08305

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b Upper Marlboro d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS 3625 Merrydale Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dawson, Baby Boy				4. DATE OF DEATH Month June Day 27 Year 1961					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1961	9. AGE (In years last birthday) ----- yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cheverly, Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Basil Kemp Dawson, Jr.				14. MOTHER'S MAIDEN NAME Phyllis Elaine Lewis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis fetalis 770-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 27, 1961 , to June 27, 1961 , that (I) (we) last saw the deceased alive on June 27, 1961 , and that death occurred at 3:40 P. M. from the causes and on the date stated above.									
22a. SIGNATURE <i>James E. Abell</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) James E. Abell, M.D.			
22d. ADDRESS 5813 Landover Road, Cheverly, Maryland				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF July 10, 1961		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town, or county) (State) Cheverly, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Harry J. Kemp, Jr.</i> Harry J. Kemp, Jr., Administrator				25a. REC'D BY REGISTRAR DATE JUL 11 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

TO ALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2077233XY1

1963

COMMERCIAL CREDIT

1963

(M)

1. Name of the company or individual to whom the credit is being extended

2. Address of the company or individual to whom the credit is being extended

3. Nature of the business or industry in which the company or individual is engaged

4. Amount of the credit being extended

5. Date of the credit being extended

6. Name of the person or persons to whom the credit is being extended

7. Name of the person or persons who are responsible for the credit being extended

8. Name of the person or persons who are responsible for the credit being extended

9. Name of the person or persons who are responsible for the credit being extended

10. Name of the person or persons who are responsible for the credit being extended

11. Name of the person or persons who are responsible for the credit being extended

12. Name of the person or persons who are responsible for the credit being extended

13. Name of the person or persons who are responsible for the credit being extended

14. Name of the person or persons who are responsible for the credit being extended

15. Name of the person or persons who are responsible for the credit being extended

16. Name of the person or persons who are responsible for the credit being extended

17. Name of the person or persons who are responsible for the credit being extended

18. Name of the person or persons who are responsible for the credit being extended

19. Name of the person or persons who are responsible for the credit being extended

20. Name of the person or persons who are responsible for the credit being extended

21. Name of the person or persons who are responsible for the credit being extended

22. Name of the person or persons who are responsible for the credit being extended

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07063

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly c. LENGTH OF STAY in 1b XXXXX 2hrs.			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 3426 Tulane Drive, Apt. 32		
3. NAME OF DECEASED (Type or print) First Middle Last Richard Lindsay Day			4. DATE OF DEATH Month Day Year June 27 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1924		9. AGE (In years last birthday) 36 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY Shipping	11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Arthur White Day			14. MOTHER'S MAIDEN NAME Dorothy Gessford		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Mr. Arthur W. Day	Address 5107 S. 10th St. Arlington 4, Va.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) fracture of the base of the skull (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driver of a car that ran into the rear of another car			
20c. TIME OF INJURY Month, Day, Year 1:09 PM 6/27/61	2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) Adelphi	(County) P.G.	(State) MD.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd			DATE SIGNED 6/27/61		
EXAMINER'S NAME (Type) James I. Boyd, M.D.			Address (Street, city, town, or county) Arlington National Ft Myer, Va.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-30-61	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Ft Myer, Va.	
23. FUNERAL DIRECTOR Lee Funeral Home - Washington D.C.			24a. REC'D BY REGISTRAR JUL 5 '61		
			24b. REGISTRAR'S SIGNATURE William S. Pious		

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14

Prince George's

Kingdom

Prince George's

County

Rocky Hill

Prince George's, General Hospital

2400 Prince Drive, Apt. 30

Robert Lindsay

June

July

July 9, 1954

Male

Male

Swedish

Minister of Columbia

U.S.A.

Arthur White Day

Lonely General

Yes

Mr. Arthur N. Day

hemorrhage and shock

fracture of the base of the skull

Driver of a car that ran into the rear of another car

1 Street

Albany

E.C.

James I. Boyd, Jr.

Washington National

14 Street, N.W.

Lee General Home - Washington D.C.

ATTENTION: COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07070

MEDICAL CERTIFICATION

1
FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, by delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07071

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 6205 Kilmer Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Frederick Deffer		4. DATE OF DEATH Month June Day 9 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) District of Columbia
13. FATHER'S NAME Phillip Deffer		14. MOTHER'S MAIDEN NAME Mary E. Haislipp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No Yes (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Doris May DiSilvestro, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary heart disease (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type)		M.D. M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/9/61	
22a. BURIAL, CREMATION, REMOVAL, or other disposition burial		22b. DATE THEREOF 6/13/61	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR ADDRESS The S.H.Hines Co., 2901 14th St. N.W. Wash, D.C.		24a. REC'D BY REGISTRAR DATE JUN 12 '61 24b. REGISTRAR'S SIGNATURE Charles S. Hines	

M

I

Male

Physician

Age

White

Residence

Phillips, Dettler

Acute congestive heart failure

Coronary heart disease

6005 Elmer Street

William Frederick Dettler

April 10, 1938

Minister of Columbia

Harry E. Webster

Mrs. Louis W. Webster, same as 2

James L. Boyd

M. D.

Witnessed by: James L. Boyd

The S.W. Hines Co., 2001 1st St. N.W., Wash., D.C.

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
7086 CERTIFICATE OF DEATH 07072													
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY P. Geo.							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CLINTON						c. LENGTH OF STAY IN 1b 6 mos.							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RT 2 Box 380						d. STREET ADDRESS RT 2 Box 380							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) LISA ELLEN DENNISON						4. DATE OF DEATH Month JUNE Day 25 Year 1961							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 6, 1960		9. AGE (In years last birthday) yrs. 6 Months 19		IF UNDER 1 YEAR Months 6 Days 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE-INFANT				10b. KIND OF BUSINESS OR INDUSTRY NONE				11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILFORD DENNISON						14. MOTHER'S MAIDEN NAME NORA SCOTT							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. NONE							
17. INFORMANT HRS. NORA DENNISON						Address RT 2 Box 380 CLINTON, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGENITAL HYDROCEPHALUS WITH SPINA BIFIDA. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) NONE												INTERVAL BETWEEN ONSET AND DEATH 1 HR. SINCE BIRTH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE MEDICAL EXAMINER) NONE						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE							
20c. TIME OF INJURY Month, Day, Year NONE 19						20d. INJURY OCCURRED While NONE at work NONE		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) NONE		20f. (City or town) (County) (State) NONE			
21. I certify that (I) (we hospital) attended the deceased from Dec. 1960 to Present , that (I) (we) last saw the deceased alive on JUNE 18, 1961 , and that death occurred at 12 NOON from the causes and on the date stated above.													
22a. SIGNATURE Arthur Shaver Jr. M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/25/61					
22c. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. M.D.						22d. ADDRESS BRANCH AVE. CLINTON, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-27-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Lutland MD							
24. FUNERAL DIRECTOR'S SIGNATURE Denmons Bros.						ADDRESS 1661-2000 HYPERSE WASH. 20 DC		25a. REC'D BY REGISTRAR DATE JUN 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

9 VVVVVVVXVV

20

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07073

7087

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>So. M.D. Hospital Center</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> d. STREET ADDRESS <u>16 West Maple Shade</u> <u>RFD - Box - 1033 Lane</u>					
3. NAME OF DECEASED (Type or print) <u>Evelyn G. Duckett</u>				4. DATE OF DEATH Last Month Day Year <u>June 1 1961</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-5-21</u>		9. AGE (In years last birthday) <u>39</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employd.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N. CAROLINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Franklin Randall</u>				14. MOTHER'S MAIDEN NAME <u>Mabel Ruth Green</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Carl S. Duckett-Same as Item #2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>633X</u> DUE TO <u>Cardiovascular collapse</u> <u>Toxemia</u> <u>Septicemia, generalized post op.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Hysterectomy & Rt Oophorectomy 5-25-61</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs. 2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/25/61</u> to <u>6/1/61</u> , that (I) (we) last saw the deceased alive on <u>6/1/61</u> and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/1/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Alfred R. Lapin, M.D.</u>				22d. ADDRESS <u>Clinton, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Salem Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Skyland N. Car.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Hanks</u>				ADDRESS <u>Arthur L. Hanks</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 6 61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for a period of 4 years. The law also requires that the death certificate be retained by the hospital or attending physician for a period of 4 years.



68050

1
FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7088

07074

Item 9 Film 6288 6/16/61 mh

1. PLACE OF DEATH e. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		42	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 2441 Valley Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Eva		Last Dunigan		4. DATE OF DEATH Month June	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5, 1895	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME MARGARET A. WATKINS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs Anna M. Lickner, Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Universal Burns of the Body (c) 979X (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Wrapped self in sheets and set them on fire					
20c. TIME OF INJURY Month, Day, Year 5:28 a.m. 6/6/1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cheverly P. G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 6/9/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-12-61		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cem.		22d. LOCATION (City, town, or country) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.				24a. REC'D BY REGISTRAR JUN 12 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7089

07075

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>2 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor 4922 La Salle Rd.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>			
d. STREET ADDRESS <u>48-17 36 St. N.W.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>K.</u> Last <u>Dunn</u>				4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25, 1880</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Dunn</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth BALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-46-0030</u>		17. INFORMANT <u>Mr. James T. Pugh 4922 La Salle Rd. Hyattsville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> 4443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1961</u> to <u>June 10, 1961</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>June 9, 1961</u> , and that death occurred at <u>0:50</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Francis P. Hannan</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 10, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS P. HANNAN</u>				22d. ADDRESS <u>1511-17 ST. N.W. WASH. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>				ADDRESS <u>3821-14th St. N.W.</u>		25. REC'D BY REGISTRAR <u> </u>	
				DATE <u>JUN 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07076

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in lb 1 1/2 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Brentwood	
3. NAME OF DECEASED (Type or print) James Ashby Ennis		f. STREET ADDRESS 4318 41 St Street	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 20, 1915	
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		10b. KIND OF BUSINESS OR INDUSTRY Loading Freight	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Franklin Ennis		14. MOTHER'S MAIDEN NAME Dorothy Ennis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII		16. SOCIAL SECURITY NO. 6	
17. INFORMANT Mrs Mary Ennis, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Coronary heart disease (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-22-61	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL		22d. LOCATION (City, town, or country) (State) FT MYER VA.	
23. FUNERAL DIRECTOR W.W. Chambers & Co		24a. REC'D BY REGISTRAR JUN 23 '61	
24b. REGISTRAR'S SIGNATURE Riversdale Md		24c. REGISTRAR'S SIGNATURE Arthur S. Kneass	

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Page 10

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Prince George's

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TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7091

07077

1. PLACE OF DEATH a. COUNTY Mont. Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 326 A S. Hampton e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter Edward Farrell		4. DATE OF DEATH Month Day Year June 25 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-33
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salman		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE 2 City & State, or foreign country New York City		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Farrell		14. MOTHER'S MAIDEN NAME Mollie Lynch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES W.W.#2		16. SOCIAL SECURITY NO. 090-14-3766	
17. INFORMANT Alice C. Barrell		Address 326 A. Southhampton Dr. Sil. Sp. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) myocardial infarction Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. myocardial infarction DUE TO (c) myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 4 months 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 25th , 19 61 , to June 21 , 19 61 , that (I) (we) last saw the deceased alive on June 21 , 19 61 , and that death occurred at 8:20 AM , from the causes and on the date stated above.			
22a. SIGNATURE Till Bergeman		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Till Bergeman		22d. ADDRESS Prince George's Hosp.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/28/61	
23c. NAME OF CEMETERY OR CREMATORY Arl. Natl. Cemetery		23d. LOCATION (City, town or county) (State) Arl. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 5801 Cleveland Ave. Riverdale Md.		25a. REC'D BY REGISTRAR JUN 28 '61	
25b. REGISTRAR'S SIGNATURE Carlton S. Kline			

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N.W. Chambers Co. 3801 Cleveland Ave. Riverside Md. Wm. 1. 10.

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be filled within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7092

07078

1. PLACE OF DEATH a. COUNTY Prince Georges Cheverly MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 33 Kentland 7656 Goodland Dr.		
3. NAME OF DECEASED (Type or print) First Middle Last Baby Ferro			4. DATE OF DEATH Month Day Year 6 17 19 61		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-17-61		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days 2 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jerome Ferro		14. MOTHER'S MAIDEN NAME M Robinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital records Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 DUE TO Prematurity (b) Premature Separation of Placenta (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-17 1961 to 6-17 1961, that (I) (we) last saw the deceased alive on 6-17 1961, and that death occurred at 6:50 PM from the causes and on the date stated above.					
22a. SIGNATURE Faud Kaibni		22b. DATE SIGNED June 17, 1961		22c. PHYSICIAN'S NAME (Type) Faud Kaibni	
22d. ADDRESS Washington D C		22e. REC'D BY REGISTRAR DATE JUN 23 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 21, 1961		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	
23d. LOCATION (City, town or county) Washington D C		23e. (State)		23f. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. ADDRESS Hyattsville, Md.		24b. (State)	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7093

07079

1. PLACE OF DEATH e. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF Hospital Andrews, AAFB, MD		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) e. STATE (D.C.) b. COUNTY (D.C.) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 20, D.C. d. STREET ADDRESS 2913 5th St, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CURT First H Middle FISCHER Last		4. DATE OF DEATH June Month 25 Day 19 61 Year				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Feb 1888	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired USARMY Bandsman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Carl Fischer		14. MOTHER'S MAIDEN NAME XXXXXXXX Selma Killig				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1912-1946		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. C.H. Fischer, 2913 5th ST, S.E., Wash 20, DC Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 204.4 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 24 Hours 3 Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that W (this hospital) attended the deceased from 20 June , 19 61 to 25 June , 19 61 , that W (we) last saw the deceased alive on 25 June , 19 61 , and that death occurred at 6:01 AM , from the causes and on the date stated above.						
22a. SIGNATURE Jerome Tilles M.D.		22b. DATE 25 Jun 61		22c. PHYSICIAN'S NAME (Type) JEROME TILLES, Captain USAF MC		
22d. ADDRESS USAF Hospital Andrews, AAFB, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-28-61		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.		23d. LOCATION (City, town or county) Arlington, Va. (State)
24. FUNERAL DIRECTOR'S SIGNATURE Sumner Bros		ADDRESS 1661--Good Hope Rd SE Washington 20 DC		25a. REC'D BY REGISTRAR JUN 27 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines

10

Index

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Item 18-289
6-29-61 ams/mb

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7094

CERTIFICATE OF DEATH

07080

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS c. LENGTH OF STAY IN 1b 1 HR 44 MIN d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS AFB MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY -- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2107 Suitland Terrace SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle JAMES Last FREY		4. DATE OF DEATH Month JUNE Day 17 Year 19 61	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17, 1961
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE R FREY		14. MOTHER'S MAIDEN NAME PATRICIA A PRESTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT FATHER, 2107 SUITLAND TERR, SE, WASHINGTON 20 DC		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY: (Immed. cause: ASPHYXIA, FETAL) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 HOUR			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 4:30		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 17, 1961 to JUNE 17, 1961 , that (I) (we) lost saw the deceased alive on JUNE 17, 1961 , and that death occurred at 4:30 A M, from the causes and on the date stated above.			
22a. SIGNATURE John R. Delahunty M.D.		22b. DATE SIGNED 6/17/61	
22c. PHYSICIAN'S NAME (Type) JOHN R DELAHUNTY, CAPT, USAF, MC		22d. ADDRESS USAF HOSPITAL, ANDREWS AFB, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/19/61	
23c. NAME OF CEMETERY OR CREMATORY Shiloh Union Cemetery		23d. LOCATION (City, town, or county) (State) York, York Co., Penna.	
24. PREVIOUS RECORDING NO. XXXXXX		25a. REC'D BY REGISTRAR Arthur S. Kraus	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE JUN 29 '61	

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Film G289 Corrected copy

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07081

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN It D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville d. STREET ADDRESS R. R. 32 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JAMES EDWARD GAITHER				4. DATE OF DEATH June 6, 1961							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 13, 1918		9. AGE (In years last birthday) 43 yrs. IF UNDER 1 YEAR: Months 6 Days 6 Hours 61 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Loader Operator				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lloyd Gaither				14. MOTHER'S MAIDEN NAME Rasa Edmunds							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) W.W. 2				16. SOCIAL SECURITY NO. 217-16-0120				17. INFORMANT Mrs. Florence Gaither Address Same as 2 above.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution DUE TO (b) Contact with high tension wires Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Operator of Crane that touched high tension wires							
20c. TIME OF INJURY Month, Day, Year 3:45 p.m. 6-6-1961				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Hyattsville P.D. Md.		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE JAMES I. BOYD, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED June 6, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify). Burial				22b. DATE THEREOF 6/9/61		22c. NAME OF CEMETERY OR CREMATORY Locus Methodist..		22d. LOCATION (City, town, or country) Simpsonville, Md.		(State) _____	
23. FUNERAL DIRECTOR Robert L. Snowden				ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR JUN 9 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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Rockville, MD

Rockville, MD

Rockville, MD

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

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FOR STATE
HEALTH DEPT.
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MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
7096 07082													
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b Dead on arrival							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John Middle Gordon						4. DATE OF DEATH June 6th., 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1897		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Navy Yard				11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George D. Gordon						14. MOTHER'S MAIDEN NAME Margaret Davidson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577-38-5141		17. INFORMANT Address Mrs Elizabeth Gordon, Same as # 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
						DATE SIGNED June 6th., 1961							
						Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF JUNE 9, 1961		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		22d. LOCATION (City, town, or country) BLADENSBURG, MARYLAND		(State)			
23. FUNERAL DIRECTOR W.W. Chambers & Co. Riverdale, Md.						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur L. Hines					
						DATE JUN 8 '61							

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7097

07083

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>105 Beech Ave</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park - 53 Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>105 Beech Ave Takoma Park</u>				d. STREET ADDRESS <u>105 Beech Ave - 1</u>			
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>II.</u> Last <u>GOSORN.</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 27 - 1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob - Martin</u>		14. MOTHER'S MAIDEN NAME <u>Mary S. Zimmerman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Lloyd Gosorn</u> Address <u>105 Beech Ave Takoma Park</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile Arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1961</u> to <u>June 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>31 May 1961</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>M. B. Queen M.D.</u>				22b. DATE SIGNED <u>6-1-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>				22d. ADDRESS <u>7112 Willow Ave Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 3, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Respect Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Talbot</u> ADDRESS <u>254 Carroll St D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

10088

CERTIFICATE OF DEATH

200

W



VS. AISME
5M 9/60

MEDICAL CERTIFICATION

1. PLACE OF BIRTH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital										2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY P. G. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Bladensburg d. STREET ADDRESS 4113 51st Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Ann Ethel Gould					4. DATE OF DEATH Month June Day 21 Year 19 61																			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 2, 1900		9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months 60		IF UNDER 24 HRS. Hours 60		Min. 60										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Own Home					11. BIRTHPLACE (State or foreign country) Tennessee					12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME Benjamin Dunn (Deceased)										14. MOTHER'S MAIDEN NAME Molly Marcus (Deceased)														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 579-05-0761					17. INFORMANT Address Sam Gould, same as # 2														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____															INTERVAL BETWEEN ONSET AND DEATH									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/22/61 ACTUAL SIGNATURE James I. Boyd M.D. EXAMINER'S NAME (Type) James I. Boyd Address (Street, city, town, or county)																								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF June 23, 1961					22c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park					22d. LOCATION (City, town, or country) (State) Falls Church, Va.									
23. FUNERAL DIRECTOR Goldberg Funeral Home										24a. REC'D BY REGISTRAR JUN 23 '61										24b. REGISTRAR'S SIGNATURE James I. Boyd				

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James George's

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James George's General Hospital

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White

Nov. 2, 1900

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On Home

Tennessee

Hopewell

Benjamin (son) (2-10-1900)

Molly (daughter) (2-10-1900)

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San Gould, Tenn. 10-19-1900

James George's General Hospital

James George's General Hospital

James I. Boyd

James I. Boyd

James I. Boyd

James I. Boyd

James I. Boyd

TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7099											
07085											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY in 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>45th Rainier</u> d. STREET ADDRESS <u>14009-29th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Richard Granzow Sr.</u>		4. DATE OF DEATH <u>6/23/61</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 8, 1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher, Ret. Safeway Stores</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
13. FATHER'S NAME <u>Ludwig Granzow</u>				14. MOTHER'S MAIDEN NAME <u>Mary Zicher</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>214-01-2527</u>			
16. SOCIAL SECURITY NO. <u>214-01-2527</u>						17. INFORMANT <u>Freida McCarthy</u> Address <u>306-34th St. N.W. Rainier 2nd</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>coronary thrombosis</u> (c) <u>arteriosclerosis heart disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>30 minutes</u> <u>18 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>January, 1941</u> to <u>June 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 23, 1961</u> , and that death occurred at <u>245 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Leon R. Hevitsky</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/23/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Leon R. Hevitsky</u>						22d. ADDRESS <u>3408 R.O. Ave. 3rd Rainier, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/26/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home, Inc.</u>						ADDRESS <u>3rd Rainier, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William L. Kraus</u>	

3893

(M)

(I)

0/20/01

1901 E. 20th St. Kansas City, Mo.

Dear Mr. Heston
I am writing to you

in regard to the matter of the
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the same as the one in the
the same as the one in the

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

7100

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07086

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Seat Pleasant c. LENGTH OF STAY IN 1b 17 yr.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Seat Pleasant d. STREET ADDRESS 8202 Central Ave 28 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) E/1a Rosetta Greene First Middle Last		4. DATE OF DEATH June 11 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1891 9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Truman Carter		14. MOTHER'S MAIDEN NAME Jane Carter Holley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) No		16. SOCIAL SECURITY NO. — 17. INFORMANT Bernard E. Hawkins Address Landover, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Carcinoma of liver (c) Carcinoma of stomach INTERVAL BETWEEN ONSET AND DEATH 1 wk Under 1. Under.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/3 1961 to 6/11 1961, that (I) (we) last saw the deceased alive on 6/10 1961 and that death occurred at 11 PM, from the causes and on the date stated above.			
22a. SIGNATURE Henry A. Wise, Jr. M.D.		22b. ADDRESS 8005 Volta St, Landover, Md.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/18/61	23c. NAME OF CEMETERY OR CREMATORY Ebenezer Methodist Ceme.	23d. LOCATION (City, town, or county) (State) St. Marys County, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Stewart ADDRESS 30 H Street, N.E.		25a. REC'D BY REGISTRAR DATE JUN 13 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Haines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7101

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07087

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS</u>		c. LENGTH OF STAY IN 1b <u>14</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL ANDREWS AFB</u>		d. STREET ADDRESS <u>OXON HILL 5126 DUMRIES ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Einar Gresham</u>		4. DATE OF DEATH Month Day Year <u>June 13 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Con</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 DEC 55</u>
9. AGE (In years lost birthday) yrs. <u>5</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>FLORIDA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDGAR LARS GRESHAM</u>		14. MOTHER'S MAIDEN NAME <u>GLORIA EVELYN LARSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FATHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laryngeal edema</u> <u>2044</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Leukemia</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Dec 55</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 55</u> 19 <u>60</u> , to <u>13 Jun</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>13 Jun</u> 19 <u>61</u> , and that death occurred at <u>2210</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John A Moore</u>		22b. DATE SIGNED <u>13 JUN 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN A MOORE, Captain USAF MC</u>		22d. ADDRESS <u>USAF HOSP, ANDREWS AIR FORCE BASE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>16 JUNE 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City, town, or county) (State) <u>ARLINGTON VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Luella Funeral Home Inc</u>		25a. REC'D BY REGISTRAR <u>CC 2</u>	
ADDRESS <u>816 HOT DR.</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Farris</u>	
DATE <u>JUN 16 '61</u>			

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(M)

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24 HOURS AFTER DEATH

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7102 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
07088											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale					
c. LENGTH OF STAY IN 1b Dead on arrival						d. STREET ADDRESS 4804 Oglethorpe Street					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Edith Middle Johanna Last Hagg						4. DATE OF DEATH Month June Day 6th. Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16th. 1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR: Months 6th. Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Stockholm, Sweden		
13. FATHER'S NAME Osterberg						14. MOTHER'S MAIDEN NAME Unknown			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. none			17. INFORMANT Mrs. Linea H. Lee Address Box 183, Mayo, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Hypertension 5 or 6 years duration											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED June 6th., 1961		
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						DEPUTY MEDICAL EXAMINER, <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-9-1961		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cem		22d. LOCATION (City, town, or country) (State) Bladensburg Md.					
23. FUNERAL DIRECTOR John M. Teyler Sons ADDRESS Annapolis Md						24a. REC'D BY REGISTRAR JUN 8 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07089

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 30 Cedar Heights d. STREET ADDRESS 1 6202 Lee Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oddie Middle Hall Last Hall Female Black 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH ? 9. AGE (in years last birthday) 41 yrs. IF UNDER 1 YEAR: Months 13 Days 19 HRS. 61		4. DATE OF DEATH Month June Day 13 Year 19 61	
5. SEX Female Black 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sol Underwood 14. MOTHER'S MAIDEN NAME MARY ? 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. --- 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulm. edema. 442X DUE TO (b) Hypertensive Cardio Va. Renal D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ---		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. --- p.m. --- 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 5-25 , 19 61 to 6-13 , 19 61 , that (I) (we) last saw the deceased alive on 6-13 - 1961 , and that death occurred at 1.10 AM from the causes and on the date stated above.		22a. SIGNATURE George J. Hageage M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Dr. George J. Hageage 22d. ADDRESS 3717 - 38th Ave., Cottage City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 6-17-61 23b. DATE THEREOF 6-17-61 23c. NAME OF CEMETERY OR CREMATORY Nat. Harmony Park 23d. LOCATION (City, town or county) Highland Park Md		24. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington & Son 25a. REC'D BY REGISTRAR DATE JUN 19 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

07020

103



Handwritten signature

112 Washington St. New York City

7104

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07090

1. PLACE OF DEATH a. COUNTY <i>Prince George Co., Laurel MARYLAND</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel R.F.D.</i>				c. LENGTH OF STAY IN 1b <i>43 yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>none</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>John Wesley Harding</i>				4. DATE OF DEATH Month Day Year <i>6 17 1961</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-8-1892</i>	9. AGE (In years last birthday) <i>69</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARPENTER</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>General Contractor Howard Co. MD</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Wesley Harding, Sr.</i>				14. MOTHER'S MAIDEN NAME <i>MARY ANN MYERS</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address <i>MRS. Geneva Harding, Laurel, Md.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Hemorrhage</i> DUE TO <i>Cancer of Lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>163X</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>3 mos. 1 year?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1/11</i> 19 <i>61</i> to <i>6/17</i> 19 <i>61</i> , that (I) (we) lost saw the deceased alive on <i>6/17</i> 19 <i>61</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>J. M. Warren</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6/19/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>J. M. WARREN</i>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>June 20, 1961</i>		<i>Emmanuel Cem.</i>		<i>Seagerville Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>De Witt Danderton Laurel, Md</i>				25a. REC'D BY REGISTRAR DATE <i>JUN 23 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

00000

CERTIFICATE OF DEATH

100

(M)

(P)

CHIEF OF BUREAU



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7105

07091

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 wks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH Month June Day 14 Year 1961							
3. NAME OF DECEASED (Type or print) First George Middle Strother Last Harrison		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> Single	
8. BIRTHPLACE (State or foreign country) Maryland		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 6 Days 14 Hours 14 Min.		11. IF UNDER 24 HRS. Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George S. Harrison, Sr.				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Browning			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year and dates of service) W.W.I				16. SOCIAL SECURITY NO. 218-03-2383		17. INFORMANT Helena Gibbons Harrison-Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 204.2 IMMEDIATE CAUSE (a) Leukemia, acute, monocytic DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 6 wks DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Broncho pneumonia				INTERVAL BETWEEN ONSET AND DEATH 6 wks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1958 to 6/14 19 61 , that (I) (we) last saw the deceased alive on 6/14 19 61 , and that death occurred at 9:15 M. from the causes and on the date stated above.							
22a. SIGNATURE Norman Donat Breaux				22b. DATE 6/14/61		22c. PHYSICIAN'S NAME (Type) NORMAN DONAT BREAUX	
22d. ADDRESS 3503 Penny St MT Rainier Md.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/17/61		23c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		23d. LOCATION (City, town, or county) (State) Upper Marlboro Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro Md.				25a. REC'D BY REGISTRAR DATE JUN 29 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1805

RECEIVED

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(M)

(1)

VS. A15ME
5M 9/60

1. PLACE OF DEATH a. COUNTY Prince George County		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3522 54th. Avenue		d. STREET ADDRESS 3522 54th. Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank		First Middle Last Hauser		4. DATE OF DEATH Month Day Year June 13, 19 61	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 1, 1873		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Joseph Hauser		14. MOTHER'S MAIDEN NAME Mary Woll	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Mrs. Edward Berry; 836 Highland Ave.; Pittsburgh (18), Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mc Keesport, Pa.	
20f. (City or town) Mc Keesport, Pa.		20g. (County) Pa.		20h. (State) Pa.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE James I. Boyd		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		Address (Street, city, town, or county) St. Marys Cemetery		24b. REGISTRAR'S SIGNATURE W.W. Chambers Co.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 17, 1961		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	
22d. LOCATION (City, town, or country) Mc Keesport, Pa.		22e. REC'D BY REGISTRAR JUN 15 '61		22f. REGISTRAR'S SIGNATURE W.W. Chambers Co.	
23. FUNERAL DIRECTOR W.W. Chambers Co.; 5801 Cleveland Ave; Riverdale, Md.		23a. ADDRESS W.W. Chambers Co.		23b. CITY, STATE, AND ZIP CODE W.W. Chambers Co.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7107
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07093

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md		c. LENGTH OF STAY IN 1b 7 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bowie, Md.		d. STREET ADDRESS Lanham Severn Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lanham Severn Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Zaida First Middle Last Haynes		4. DATE OF DEATH June 16 19 61	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William F Rippetoe		14. MOTHER'S MAIDEN NAME Susan C Bond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Louis Haynes		Address University estates, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis with Infarction Hypertensive Inter-arteriole Heart Disease Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes year year 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 19 1954 to 6/16 19 61, that I last saw the deceased alive on 6/10 19 61, and that death occurred at 1000 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) R F D Bowie, Md.	
ACTUAL SIGNATURE H. James Kurtz M.D.		DATE SIGNED 6/16/61	
PHYSICIAN'S NAME (Type) H. James Kurtz		R F D Bowie, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 19, 1961	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE JUN 20 1961		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1. Name of Deceased: *John A. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of Birth: *1910*

5. Date of Death: *1955*

6. Place of Death: *Home*

7. Cause of Death: *Heart Disease*

8. Physician: *Dr. J. B. Jones*

9. Burial Place: *St. John's Cemetery*

10. Registrar: *John A. Smith*

11. Signature: *[Signature]*

12. Date: *1955*

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FOR STATE
HEALTH DEPT.

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899

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VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>7108</div> <div>07094</div> </div> </div> <div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>7108</div> <div>07094</div> </div> </div> <div> <div> <div>VS. A15ME</div> <div>5M 9/60</div> </div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2506 33rd Street S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Joseph Einar Hedberg 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH April 14, 1901 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						4. DATE OF DEATH June 2, 1961 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer 10b. KIND OF BUSINESS OR INDUSTRY Retired 11. BIRTHPLACE (State or foreign country) Sweden 12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 881-10-7620 17. INFORMANT Mrs Hildur S. Hedberg, same as # 2 Address						14. MOTHER'S MAIDEN NAME Unknown 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Coronary heart disease DUE TO (c) 420.1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/2/61 ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF 6.5.1961 22c. NAME OF CEMETERY OR CREMATORY Lee's Crematory 22d. LOCATION (City, town, or country) (State) Washington. D C.						23. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E Wash. D C ADDRESS 24a. REC'D BY REGISTRAR JUN 20 '61 24b. REGISTRAR'S SIGNATURE Charles S. Thomas					

VS. A15ME
5M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7109

07095

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 2 yrs., 10 mo., & 29 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
		d. STREET ADDRESS 825 5th St., N. W.	
e. US RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Tillman - Hinson		4. DATE OF DEATH Month Day Year 6 12 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/5/06
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days - -	IF UNDER 24 HRS. Hours Min. - -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron worker		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (County & State, or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William M. Hinson		14. MOTHER'S MAIDEN NAME Nettie Folson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1923 - 1924		16. SOCIAL SECURITY NO. 577-16-8415	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tbc., far advanced 002 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yr. 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cor pulmonale; pulm. emphysema; severe coronary atherosclerosis with occlusion of distal portion left coronary artery (terminal)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/14/1958 to 6/12/1961 , that (I) (we) last saw the deceased alive on 6/12/1961 , and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 6/12/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 6/14/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL		23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Reside. Funeral Home 816 H St. N.E.		25a. REC'D BY REGISTRAR DATE JUN 15 '61	
25b. REGISTRAR'S SIGNATURE Robert S. Evans			

VR A15 (4)
15M 9/60

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(M)

Washington

1-15-45

General (Info) (copy)

General (Info) (copy)

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General (Info) (copy)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
7110									
07096									
1. PLACE OF DEATH a. COUNTY MARYLAND Prince George's					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland 33			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General					d. STREET ADDRESS 7629 Inwood Street				
3. NAME OF DECEASED (Type or print) Joan Marie Hood First Middle Last					4. DATE OF DEATH Month June Day 25 Year 1961				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1961		9. AGE (In years last birthday) yrs. 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None--Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cheverly, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Donald Hood					14. MOTHER'S MAIDEN NAME Lula Fay Sims				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Donald E. Hood, 7629 Inwood St., Kentland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO Congenital hth. dis. (cardiomyopathy) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from June 23, 1961 to June 25, 1961 , that (I) (we) last saw the deceased alive on June 25, 1961 , and that death occurred at 8:26 A.M. from the causes and on the date stated above. 22a. SIGNATURE Julius Kauffman 22c. PHYSICIAN'S NAME (Type) Julius Kauffman, M.D. 22b. DATE SIGNED 22d. ADDRESS 5102 Annapolis Road, Bladensburg, Md. 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/28/1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc. 517-11th St. S.E.					25a. REC'D BY REGISTRAR DATE JUN 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline		

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June 23

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June 23

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3025 Annapolis Road, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7111

07097

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Rainier c. LENGTH OF STAY IN 1b 4602 Russell Ave d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 4602 Russell Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James William Hoffman		4. DATE OF DEATH Month June Day 30 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/ 1873
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (County & State, or foreign country) D. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William G. Hoffman	
14. MOTHER'S MAIDEN NAME Agnes B. Shehan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 218-01-2749 17. INFORMANT Mrs Marie Ashford	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		INTERVAL BETWEEN ONSET AND DEATH 1-2 Hours YEARS.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1958 to 6/30, 1961 , that (I) (we) last saw the deceased alive on 6/30, 1961 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE C. James Duke 22c. PHYSICIAN'S NAME (Type) C. James Duke		22b. DATE SIGNED June 30 1961 22d. ADDRESS 6607 Riverdale Rd, Riverdale, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/3/1961	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet	23d. LOCATION (City, town or county) (State) Bladensburg DC
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300 4th. St.N.E. D.C.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE JUL 5 '61 Arthur L. Hanna	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

07098

7112

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CHEVERLY NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>200 WALNUT ST. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LIDIE E. Hughes</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 21, 1873</u> 9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DARLINGTON, MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHARLES HAWKINS</u>		14. MOTHER'S MAIDEN NAME <u>SARAH JONES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <u>Greta Clary</u> Address <u>1725 9. St. S.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 yrs.</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 29, 1961</u> , to <u>June 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 3, 1961</u> , and that death occurred at <u>10</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Samuel Sugar</u> M.D.		22b. DATE SIGNED <u>6-3-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL SUGAR</u>		22d. ADDRESS <u>4637 EASTERN AVE</u> <u>WASH DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Smithland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Free Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7113

07099

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marguerite Middle Hurder Last Hurder				4. DATE OF DEATH Month June Day 20 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 June 1895	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Zacharius Moyer				14. MOTHER'S MAIDEN NAME Agnes Muhl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Hospital Records - Cheverly, Md -			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Diabetic Coma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 17, 19 61 , to June 20, 19 61 , that (I) (we) last saw the deceased alive on June 19, 19 61 , and that death occurred at 6:10 AM from the causes and on the date stated above.							
22a. SIGNATURE Dr. H Wodak				22b. DATE SIGNED June 19, 19 61		22c. PHYSICIAN'S NAME (Type) Dr. H Wodak., M.D.	
22d. ADDRESS Greenbelt., Md				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 6/20/61		23c. NAME OF CEMETERY OR CREMATORY Lansford		23d. LOCATION (City, town, or county) (State) Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE F. Bracke Sons Hyattsville Md -				25a. REC'D BY REGISTRAR DATE JUN 23 '61		25b. REGISTRAR'S SIGNATURE William L. Kline	

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07109

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 1528.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hospital		d. STREET ADDRESS 2105 Linden Lane	
3. NAME OF DECEASED (Type or print) Baby Girl First Middle Last Jensen		4. DATE OF DEATH Month 6 Day 15 Year 1961	
5. SEX Fe	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-61
9. AGE (In years last birthday) - yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min. 10 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Thomas John Jensen	
14. MOTHER'S MAIDEN NAME Ethel May Macurdy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Embolism 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Exhaustion DUE TO (c) Prematurity		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-15-1961 to 6-15-11 P.M. 1961, that (I) (we) last saw the deceased alive on 6-15-1961, and that death occurred at 11 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Hase		22b. DATE SIGNED June 15, 1961	
22c. PHYSICIAN'S NAME (Type) CHARLES HASE		22d. ADDRESS Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/17/61	
23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION (City, town or county) (State) Bladensburg, Md	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gascha		25a. REC'D BY REGISTRAR DATE JUN 20 '61	
25b. REGISTRAR'S SIGNATURE Clinton S. Hume			



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James John Jensen - 1900 May 1st

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07101

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY in 1b D.O .A			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oliver Middle Garratt Last Landon				4. DATE OF DEATH Month June Day 19, Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 11, 1902	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58		IF UNDER 24 HRS. Hours 58 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger				10b. KIND OF BUSINESS OR INDUSTRY Decorating		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Landon				14. MOTHER'S MAIDEN NAME Dora Viola Garratt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 217-14-7342			
17. INFORMANT 4503^{dr.} Brookes Drive S.E.				Washington 23, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary heart disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/19/61 Address (Street, city, town, or county)							
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type)					
22b. DATE THEREOF Burial June 22 - 61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or country) (State) Suitland, Maryland			
23. FUNERAL DIRECTOR Seminars Bros		ADDRESS 1461 - 94 Hope Rd SE		24a. REC'D BY REGISTRAR HUN 21 '61		24b. REGISTRAR'S SIGNATURE Walter S. Thomas	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7116

CERTIFICATE OF DEATH

07102

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN lb <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Lanham</u> d. STREET ADDRESS <u>5920 Prince Garden Pkwy</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Lanham</u> Last <u>Lanham</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1961</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>14 June 1903</u> 9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Capital Air lines</u> 11b. KIND OF BUSINESS OR INDUSTRY <u> </u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
13. FATHER'S NAME <u>Stephen C Lanham</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Baldwin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Anna Lanham</u> Address <u>Lanham Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Emboli</u> DUE TO <u>Uremia and Electrolyte Imbalance</u> (b) <u>Renal Infarction secondary to infarction of left renal artery.</u> DUE TO <u>Intestinal Obstruction secondary to adhesions</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Malignant Carcinoid tumor of the Small Intestine</u>				INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>4-1-1</u> 19 <u>60</u> , to <u>6-6-61</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>1.10 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. A Deitz, M.D.</u>		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> 22d. ADDRESS <u>Hyattsville., Md</u>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. DATE SIGNED <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>June 9, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Lanham Methodist Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Lanham Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u> 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u> DATE <u>JUN 12 '61</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(1)

Settled

June 1, 1931
W. A. ...
W. A. ...
W. A. ...

TO BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL OR CREMATION. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE COMPLETED WITHIN 24 HOURS AFTER DEATH. THE DEATH CERTIFICATE MAY BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. THE FUNERAL DIRECTOR: AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7117

07103

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 h rs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph T Lewis		d. STREET ADDRESS 5711 Newton St.	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 22 Nov 1901	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 9 Days 19 Hours 61	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. News stand		11b. KIND OF BUSINESS OR INDUSTRY Washington D C.	
13. FATHER'S NAME Joseph Lewis		14. MOTHER'S MARDEN NAME Emma Horton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give year or dates of service) 4201		16. SOCIAL SECURITY NO. 578.09.9893	
17. INFORMANT Mary Lewis.5711.Newton st Cheverly.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion(left anterior descending) DUE TO (c) Cornoary Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20f. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/9 , 19 61 , to 6/9 , 19 61 , that (I) (we) last saw the deceased alive on 6/9 , 19 61 , and that death occurred 6,50A , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Barry Rosenberg		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Barry Rosenberg M.D.		22d. ADDRESS 1210 Chillum Manor Rd. W. Hyattsville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6.12.1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill.Cemetery		23d. LOCATION (City, town or county) (State) Suitland. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 3004 N. E. Paul D. C.		25a. REC'D BY REGISTRAR DATE JUN 13 '61	
25b. REGISTRAR'S SIGNATURE Charles E. Fisher			

(M)

(I)

Joseph Lewis

James Norton

Washington D.C.

578.09.9393 Mary Lewis, 5711. Newton St. Beverly, Ca.

Barry Rosenberg

Encl. 6.12.1951 Cedar Hill Cemetery Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7118

07104

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pr. Geo. Gen. Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Univ., Park d. STREET ADDRESS 4304 Underwood St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carl A. Luenser		4. DATE OF DEATH Month June Day 4 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 March 1891
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Butcher	11. BIRTHPLACE (County & State, or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Julius Luenser	
14. MOTHER'S MAIDEN NAME Unk.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 399097831	
16. SOCIAL SECURITY NO. 399097831		17. INFORMANT Marian L. Kohn Address Same as # 2 (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion w/ 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarct (c) arteriosclerosis heart disease		INTERVAL BETWEEN ONSET AND DEATH 16 h years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 3rd , 19 61 , to June 4th , 19 61 , that (I) (we) last saw the deceased alive on June 4th , 19 61 , and that death occurred at 9:15 M, from the causes and on the date stated above.			
22a. SIGNATURE Till Bergemann		22b. DATE SIGNED June 4th 1961	
22c. PHYSICIAN'S NAME (Type) Till BERGEMANN		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Transit, Burial		23b. DATE THEREOF 6/8/61	
23c. NAME OF CEMETERY OR CREMATORY Merrill Cemetery		23d. LOCATION (City, town or county) (State) Merrill Wisc..	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR JUN 8 '61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VI

Prince George

Shaverly

Mr. Geo. Gen. Hosp.

Carl

White

White

Latino

John Linnson

I

33507851

Marion L. Linn

(Daughter)

Unk.

Germany

Alphon

8 March 1881

Latino

A.

Univ., Park

U.S.A.

1304 Underwood St.

Mr. Geo.

Marion

Marion Cemetery

Marion Cemetery

Marion's sons Hyattsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7119

07105

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D. C. b. COUNTY 41X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				d. STREET ADDRESS 3008--W--St., S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle T. Last MACKINTOSH Sr.		4. DATE OF DEATH Month June Day 21 Year 19 61					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12th 1873	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Washington Terminal Railroad		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry I. Mackintosh				14. MOTHER'S MAIDEN NAME Mary Louise Lavezzi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT James T. Mackintosh, Jr. Same as # 2-c-d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO (b) Myocardial insufficiency DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy						INTERVAL BETWEEN ONSET AND DEATH 10 min. 10 yrs. 20 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 8, 1961, to June 21, 1961, that (I) (we) last saw the deceased alive on June 20, 1961, and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Leo H. Magnuson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/21/61	
22c. PHYSICIAN'S NAME (Type) Leo H. Magnuson MD				22d. ADDRESS 2711 gai ther A. SE. WASH DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24, 1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Scimont Biol				ADDRESS 1661--Good Hope Rd S.E. Washington 20 DC		25a. REC'D BY REGISTRAR DATE JUN 23 '61	
				25b. REGISTRAR'S SIGNATURE			

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

1911

(M)

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07106

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 9139 Baltimore Blvd.			
3. NAME OF DECEASED (Type or print) First Arthur Middle Clifton Last Madison, Sr.				4. DATE OF DEATH Month June Day 29th. Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12th. 1909	
9. AGE (In years last birthday) 51 Yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Construction			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ernest L. Madison				14. MOTHER'S MAIDEN NAME Mary E. Lipscomb			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) none				16. SOCIAL SECURITY NO. 579-01-5146			
17. INFORMANT Mrs. Mary Madison				Address Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF July 3, 1961		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or country) (State) Bladensburg Maryland	
23. FUNERAL DIRECTOR W.W. Chambers & Co. Riverdale, Md.				24a. REC'D BY REGISTRAR Jul 3 '61			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

DATE SIGNED
June 30th., 1961

17

THE STATE
OF NEW YORK

James George
Huntley

James George
Huntley

James George
Huntley

James George
Huntley

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
7121 Item 12, Film 0289 6/26/61 ink 07107											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 21 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor d. STREET ADDRESS 3417 39th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Josephine Malpasso						4. DATE OF DEATH Month Day Year 8 June 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-11-01		9. AGE (In years last birthday) 59 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home				11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Viviano				14. MOTHER'S MAIDEN NAME Filippa Muccio							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 103-26-2914				16. SOCIAL SECURITY NO. 103-26-2914				17. INFORMANT Joseph F. Malpasso, 4058-Adams Drive Silver Spring Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of the Sigmoid Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 year 3 years										INTERVAL BETWEEN ONSET AND DEATH 1 year 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 19		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to June 8, 1961 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 1:40 PM from the causes and on the date stated above.											
22a. SIGNATURE Dayton O Watkins M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) DAYTON OWATKINS						22d. ADDRESS 5818 Annapolis Rd Beltsville Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) (State) Arlington Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.						ADDRESS Mr. Rainier Maryland		25a. REC'D BY REGISTRAR DATE JUN 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Miller	

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STATE OF CALIFORNIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7122

07108

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 3 months and 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4502 S. Cap. St., S.E., Apt 201 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Peter A. Manley 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6/17/1889 9. AGE (In years last birthday) 72 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (plumber) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Pa. 12. CITIZEN OF WHAT COUNTRY? USA		4. DATE OF DEATH Month 6 Day 29 Year 1961 IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME Patrick Manley 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 196-01-4466 17. INFORMANT Decedent Address		14. MOTHER'S MAIDEN NAME Anne Corcoran	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) Pulmonary tuberculosis, far advanced PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary fibrosis and emphysema 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH Unknown 2 yrs., 6 mos.	
21. I certify that (I) (this hospital) attended the deceased from 3/27/ 1961 to 6/29/ 1961, that (I) (we) last saw the deceased alive on 6/29/ 1961 and that death occurred at P. M., from the causes and on the date stated above. 22a. SIGNATURE Moe Weiss 22b. DATE SIGNED 6/29/61 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 3-61 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill 23d. LOCATION (City, town or county) (State) Suitland, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE Semmons Bros. 1661 Good Hope Rd SE 25a. REC'D BY REGISTRAR DATE JUL 3 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7123

CERTIFICATE OF DEATH

07109

1. PLACE OF DEATH a. COUNTY Pr. Geo. MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4609 Oliver Street				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 65 Riverdale d. STREET ADDRESS 4609 Oliver Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FANNIE RAWLINGS McCATHRAN		4. DATE OF DEATH Month 6 Day 23 Year 1961		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 13. FATHER'S NAME Arthur Clements		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Lanham, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR: Months 23 Days 19 Hours 61 Min.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no		17. INFORMANT Arthur McCathran Address Riverdale, Md. 4609 Oliver St.,					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency 4221 DUE TO (b) Arteriosclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Arteriosclerosis Generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Atopic dermatitis Generalized, Malnutrition 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from Oct 1960 to 23 June 1961 that (I) (we) last saw the deceased alive on 23 June 1961 and that death occurred at 5 P.M. from the causes and on the date stated above. 22e. SIGNATURE Thomas P. Fogarty M.D. 22b. DATE SIGNED 23 June 61 22c. PHYSICIAN'S NAME (Type) Thomas P. Fogarty 22d. ADDRESS 1011 UNIV. BLVD E SILVER SPRING Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) 6/27/61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			
23d. LOCATION (City, town or county) Pr. Geo. Co., Maryland		24 FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. ADDRESS Wash. D.C.					
25a. REC'D BY REGISTRAR JUN 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines					

SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 07110

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glassmanor (Wash.21,DC)		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 248 Audrey Lane, S.E.		d. STREET ADDRESS 248 Audrey Lane, S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BEATRICE (BEA) First Middle Last W. McDONNELL		4. DATE OF DEATH June 17th, 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27th, 1891
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Ashley, Penna.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Paul H. McDonnell, 248 Audrey Lane, S.E. Wash. 21 DC.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY , 1960, to JUNE 17 , 1961, that I last saw the deceased alive on JUNE 17 , 1961, and that death occurred at 1 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4833 St. BARBARA Rd. WASH. 21 DC. DATE SIGNED 6/17/61			
ACTUAL SIGNATURE Bruno Kallegh M.D.			
PHYSICIAN'S NAME (Type) BRUNO KALLEGH		TEMPLE HILLS - MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/20/1961	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Help of Christian Cem.	22d. LOCATION (City, town, or county) (State) Pittston, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, 517--11th St. S.E. Wash. DC		24a. REC'D BY REGISTRAR JUN 21 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES M. JONES		AGE 35		SEX Male		RACE White		DATE OF BIRTH 1910		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married		RELIGION Catholic		DATE OF DEATH 1945		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PERIOD OF ILLNESS 2 weeks		DATE OF ONSET 1945		DATE OF REPORT 1945		REPORTED BY Physician	
SIGNATURE OF PHYSICIAN J. M. Jones		SIGNATURE OF REPORTER J. M. Jones		SIGNATURE OF WITNESS J. M. Jones		SIGNATURE OF DECEASED J. M. Jones		SIGNATURE OF NEXT OF KIN J. M. Jones		SIGNATURE OF CLERK J. M. Jones	

NAME OF DECEASED JAMES M. JONES		AGE 35		SEX Male		RACE White		DATE OF BIRTH 1910		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married		RELIGION Catholic		DATE OF DEATH 1945		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PERIOD OF ILLNESS 2 weeks		DATE OF ONSET 1945		DATE OF REPORT 1945		REPORTED BY Physician	
SIGNATURE OF PHYSICIAN J. M. Jones		SIGNATURE OF REPORTER J. M. Jones		SIGNATURE OF WITNESS J. M. Jones		SIGNATURE OF DECEASED J. M. Jones		SIGNATURE OF NEXT OF KIN J. M. Jones		SIGNATURE OF CLERK J. M. Jones	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7125

07111

1. PLACE OF DEATH e. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 69 College Park d. STREET ADDRESS 9636 51st Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MADELINE FRANCES MILLER				4. DATE OF DEATH Month Day Year June 16 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-26-14	
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Leroy Bresnahan				14. MOTHER'S MAIDEN NAME Arvella M. Mathews			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 253X Acute Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (b) Coronary Artery Atherosclerosis (a), stating the underlying cause last. } DUE TO (c) Post-Operative Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mild Cardiac Decompensation, Bronchopneumonia							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-13 , 19 61 , to 6/16 , 19 61 ; that (I) (we) last saw the deceased alive on 6-16 , 19 61 , and that death occurred at 1:25P from the causes and on the date stated above.							
22a. SIGNATURE William Eisner M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-16-61	
22c. PHYSICIAN'S NAME (Type) William Eisner				22d. ADDRESS 30. B Ridge Rd, Greenbelt, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 19, 1961		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JUN 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7126 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07112

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. STREET ADDRESS Seabrook			
3. NAME OF DECEASED (Type or print) First Middle Last George Winfield Morgan Jr				4. DATE OF DEATH Month Day Year June 30, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1941	
9. AGE (In years last birthday) 20		10. IF UNDER 1 YEAR Months Days 0 0		11. IF UNDER 24 HRS. Hours Min. 0 0		12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy			
11. BIRTHPLACE (State or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Winfield Morgan Sr				14. MOTHER'S MAIDEN NAME Alice Grace Weed			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes				16. SOCIAL SECURITY NO. Now			
17. INFORMANT Miss Mary E. Morgan., same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest, fracture of the skull, fracture of the facial bones DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of a motor cycle struck by an automobile			
20c. TIME OF INJURY Hour 11:23 p.m. Month, Day, Year 6/30/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Seabrook P. G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 7/1/61			
22b. DATE THEREOF July 5, 1961				22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			
22d. LOCATION (City, town, or country) (State) Suitland Md.				24e. REC'D BY REGISTRAR 7/1/61			
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

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Director of Columbia

George Winfield Morgan Jr.

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Miss Mary E. Kington, June 22, 1892

U.S. Department of Health and Human Services

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CERTIFICATE OF DEATH

Reg. Dist. No.

07113

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-UPPER HARBORO</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-UPPER HARBORO</u>			
c. LENGTH OF STAY IN 1b <u>4 YRS</u>				d. STREET ADDRESS <u>Box 4137</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 4137</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SHELTON</u>		First <u>MATTHEW</u> Middle <u>NEWMAN</u> Last		4. DATE OF DEATH <u>JUNE 24</u>		Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 16, 1956</u>		9. AGE (In years last birthday) <u>4</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ANTHONY NEWMAN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH SWANKI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>FATHER</u> Address <u>Box 4137</u>		17. <u>JOHN ANTHONY NEWMAN UPPER HARBORO</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> 292.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE SICKLE CELL CRISIS</u> DUE TO (c) <u>SICKLE CELL ANEMIA</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u> <u>16 HRS.</u> <u>SINCE BIRTH</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE UPPER RESPIRATORY INFECTION</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year <u>NONE</u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> While away from work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>NONE</u>		20f. (City or town) (County) (State) <u>NONE</u>	
21. I certify that I attended the deceased from <u>MARCH</u> , 19 <u>57</u> , to <u>PRESENT</u> , that I last saw the deceased alive on <u>JUNE 23</u> , 19 <u>61</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Branch Ave. Clinton Md</u> DATE SIGNED <u>6/24/61</u> ACTUAL SIGNATURE <u>Arthur Shaver Jr. M.D.</u> PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. M.D. BRANCH AVE. CLINTON MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-26-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Roseville Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Roseville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Found Home</u> ADDRESS <u>Waldorf, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

PERSONAL RECORD
LOCAL HEALTH OFFICE
DATE OF DEATH
PLACE OF DEATH
AGE
SEX
RACE
EDUCATION
OCCUPATION
MARRIAGE
CHILDREN
RELIGION
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE
DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7128

CERTIFICATE OF DEATH

07114

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b 16 days		d. STREET ADDRESS 5801 15th Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leonard J Noone		4. DATE OF DEATH Month June Day 6 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 June 1920	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James B Noone		14. MOTHER'S MAIDEN NAME Ellen B Kelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213 12 1099	
17. INFORMANT Madeline F Noone		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 162.1 DUE TO (b) BRONCHOGENIC CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 2-3 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/21 , 19 61 , to 6/6 , 19 61 , that (I) (we) last saw the deceased alive on 6/5 , 19 61 , and that death occurred at 5:45 AM from the causes and on the date stated above.			
22a. SIGNATURE C. J. Duke		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. C. J. Duke M.D.		22d. ADDRESS 6607 Riverdale Road Riverdale, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 8, 1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR JUN 8 '61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7129 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07115

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District Columbia b. COUNTY District Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN TB Dead on arrival		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS Washington 1912 Calvert St., N.W.		
3. NAME OF DECEASED (Type or print) Lester Harry Ondriezek			4. DATE OF DEATH June 6th., 1961		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		9. AGE (In years last birthday) 19 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY Car Rental		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.-C	
13. FATHER'S NAME Thomas Ondriezek			14. MOTHER'S MAIDEN NAME Eleanor Davis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes 4 mos.			16. SOCIAL SECURITY NO. yes		
17. INFORMANT Mrs. Janet Ondriezek Same as #2			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 819+ DUE TO Crushed chest Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an auto that struck a fixed object		
20c. TIME OF INJURY Month, Day, Year Hour, e.m. 3:40 p.m. 6-6-1961			20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road			20f. (City or town) Upper Marlboro P-g. Co. (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6-10-61		
22c. NAME OF CEMETERY OR CREMATORY Pineland Cemetery			22d. LOCATION (City, town, or country) (State) Strangtown, Pa.		
23. FUNERAL DIRECTOR W.W. Chambers & Co. Pikesville, Md.			24. REC'D BY REGISTRAR JUN 8 '61		
			24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 and 6 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Maryland b. COUNTY		Prince George's Talbot	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS		20X-2			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year			
Prince George's General Hospital		JOHN THOMAS OWENS		June 29th., 19 61					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		May 7th., 1896		65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Laborer		Farmer		Maryland		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Charles Owens		Annie V. Simms							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes		W.W. 1		Mrs. Henrietta Owens		same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		Acute Congested Heart Failure							
442X DUE TO		Cardiovascular							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Endocarditis Renal Disease					
		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part-II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While Not While et work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		JAMES I. BOYD, M.D.		JUNE 29th., 1961					
EXAMINER'S NAME (Type)		JAMES I. BOYD, M.D.		Address (Street, city, town, or county)					
22b. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)			
Burial		7-3-61		Galilee		Mitchellsville, Maryland			
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
C.E.HICKS 111		Annapolis, Md.		JUL 6 '61		Arthur L. Kraus			

File 100-21

Best Practice

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1546

Death on arrival

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Discussion

U.S.A.

Charles Evans

Annex 7

100

Mr. Hamilton

Ames Corporation
Corporation
Ames Corporation

JAMES E. ROY, M.D.

1001, 1002, 1003

III INDEX 8.0

1000

CORONER'S DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

CHIEF FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. Its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07117

1. PLACE OF DEATH a. COUNTY	Prince George's	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE	Maryland	b. COUNTY	Prince George's		
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Cheverly		c. LENGTH OF STAY IN lb		DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Hyattsville
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
	James	Fletcher	Parker Jr		June	18	19 61	
5. SEX	Male	6. COLOR OR RACE	White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Accountant	10b. KIND OF BUSINESS OR INDUSTRY	Retired	11. BIRTHPLACE (State or foreign country)	North Carolina	12. CITIZEN OF WHAT COUNTRY?	U.S.A.	
13. FATHER'S NAME	James Fletcher Parker Sr.	14. MOTHER'S MAIDEN NAME	Elizabeth Cromartie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)	Yes	16. SOCIAL SECURITY NO.	214-28-4737	17. INFORMANT	Mrs. Ruth Parker	Address	1801 Drexel Street Apt 16	Hyattsville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY INSUFFICIENCY 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERIOSCLEROSIS and Hypertrophy, heart DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	19	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE	James I. Boyd	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED	6/18/61		
EXAMINER'S NAME (Type)	James I. Boyd, M.D.	Address (Street, city, town, or county)						
22a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	22b. DATE THEREOF	6-21-1961	22c. NAME OF CEMETERY OR CREMATORY	ARLINGTON NATL	22d. LOCATION (City, town, or country)	FT MYER	(State)
23. FUNERAL DIRECTOR	W.W. Chambers Co	ADDRESS	5801 Cleveland Ave	24a. REC'D BY REGISTRAR	DATE	JUN 21 '61	24b. REGISTRAR'S SIGNATURE	Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7132

CERTIFICATE OF DEATH

07118

Items 3/8/16, Film G 291 7/19/61 iml

1. PLACE OF DEATH a. COUNTY <i>Prince Geo.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel Md. 02</i>	
c. LENGTH OF STAY IN 1b <i>12 days</i>		d. STREET ADDRESS <i>2013 Sandy Spring Rd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Eugene Leland Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Vernon William Parsley</i>		4. DATE OF DEATH Month <i>6</i> Day <i>8</i> Year <i>19 61</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/14/1877</i>
9. AGE (In years last birthday) <i>84 yrs.</i>		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John William Parsley</i>		14. MOTHER'S MAIDEN NAME <i>Mary Rebecca Gingles</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>218-21-0308</i>	
17. INFORMANT <i>Hospital Records</i>		Address <i>4408 Queensburg Riverdale, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i> <i>331X</i> DUE TO <i>Cerebrovascular Accident</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>May 27, 1961</i> to <i>June 8, 1961</i> , that (I) (we) last saw the deceased alive on <i>June 8, 1961</i> , and that death occurred at <i>7:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Theo Zegarra M.D.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Theo. Zegarra, M.D.</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 11, 1961 Union Cem.</i>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <i>Burtonville, Md</i>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>De W. McDonald</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 19 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>			

1915

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7133

CERTIFICATE OF DEATH

07119

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Md. Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u> RURAL d. STREET ADDRESS <u>08 X-2</u>										
3. NAME OF DECEASED (Type or print) <u>PICKERAL, OLIVER</u>		4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										
8. DATE OF BIRTH <u>3-28-93</u>		9. AGE (In years last birthday) <u>68</u> yrs. <table border="1" style="display: inline-table; font-size: 0.8em;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.												
Months	Days	Hours	Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chas. Co Md</u>										
13. FATHER'S NAME <u>JAMES PICKERAL</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES WILLETT</u>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>EMMETT PICKERAL</u>		17. INFORMANT Address <u>WALDORF Md</u>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; font-size: 0.9em;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Auto myocardial infarction</u> </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> </td> </tr> <tr> <td rowspan="2" style="vertical-align: middle;"> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. </td> <td> (b) <u>Arteriosclerotic heart disease</u> </td> </tr> <tr> <td> (c) <u>Severe generalized arteriosclerosis</u> </td> </tr> <tr> <td colspan="3"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Severe chronic pulmonary emphysema</u> </td> </tr> </table>						PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Auto myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.	(b) <u>Arteriosclerotic heart disease</u>	(c) <u>Severe generalized arteriosclerosis</u>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Severe chronic pulmonary emphysema</u>		
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Auto myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>												
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.	(b) <u>Arteriosclerotic heart disease</u>													
	(c) <u>Severe generalized arteriosclerosis</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Severe chronic pulmonary emphysema</u>														
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										
20f. (City or town)		(County)		(State)										
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.														
22a. SIGNATURE <u>O.W. Eldridge</u>		22b. DATE SIGNED M.D.		22c. PHYSICIAN'S NAME (Type) <u>O.W. Eldridge</u>										
22d. ADDRESS <u>CLINTON Md</u>		22e. REC'D BY REGISTRAR												
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-12-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND Cem.</u>										
23d. LOCATION (City, town or county) <u>WALDORF</u>		(State) <u>Md</u>												
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		25a. ADDRESS <u>Waldorf Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>										
25c. DATE <u>JUN 14 '61</u>														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

(M)

(I)

George George

Clinton

2010-11-10

Pickens, Oliver

M. W.

THOMAS

James P. Kester

Wm

FRANCIS W. H. H.

FRANCIS W. H. H.

FRANCIS W. H. H.

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FRANCIS W. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7134

07120

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> <u>Accokeek</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Accokeek</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>TOWNLEY L. PICKERAL</u>		4. DATE OF DEATH Month Day Year <u>JUNE 15, 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3, 1889</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIDNEY PICKERAL</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. MURPHY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MAGGIE PICKERAL, ACCOKEEK, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>THROMBOSIS OF CORONARY ARTERY</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause test. (b) <u>CEREBROSCLEROSIS</u> (c) <u>GENERAL ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 18th 1958</u> to <u>Jun. 15th 1961</u> , that (I) (we) last saw the deceased alive on <u>Jun. 1st 1961</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul Chen</u> M.D.		22b. DATE SIGNED <u>Jun. 15th, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL CHEN, M. D.</u>		22d. ADDRESS <u>Accokeek, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-17-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND</u>		23d. LOCATION (City, town or county) (State) <u>WALDORF, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, WALDORF, MD</u>		25a. REC'D BY REGISTRAR <u>JUN 19 '61</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Caring & Trust</u>	



07121

Arthur S. Kraus

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

(M)
(O)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7136

Item 9 Film 3259

6/23/61 iwk

07122

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>1 yr 6 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor 4922 La Salle Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>B.</u> Last <u>Price</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1890</u>
9. AGE (In years, last birthday) <u>70 71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veteran's Adminstr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vet. Adm.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Lennon</u>		14. MOTHER'S MAIDEN NAME <u>Rose Gallagher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dr. M. Bernadette Joseph</u>		Address <u>4922 La Salle Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS c MYOCARDIAL INFARCTION</u> 722.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RHEUMATOID ARTHRITIS</u> (c) <u>ONE DAY</u> 4 YEARS		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAR - 1</u> 19 <u>61</u> to <u>JUNE 17</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>JUNE 14</u> 19 <u>61</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. Collins MD</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>		22d. ADDRESS <u>322-H. St. N.E. Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-20-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		25a. REC'D BY REGISTRAR <u>JUN 20 '61</u>	
ADDRESS <u>3821-14 H. St. N.W. Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

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RECEIVED

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DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

CO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07123

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY Prince George's	2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE Maryland	3. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) c. COUNTY Prince George's	
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	c. LENGTH OF STAY IN 1b 56	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	d. STREET ADDRESS 1801 Jasmine Terrace
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1801 Jasmine Terrace	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	4. DATE OF DEATH June 18 1961	5. SEX Male
	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/5/10
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	10b. KIND OF BUSINESS OR INDUSTRY AMER. HOME IMP. CO	11. BIRTHPLACE (State or foreign country) N. CAROLINA	12. CITIZEN OF WHAT COUNTRY? U. S. A
	13. FATHER'S NAME ANDREW FOY EDWIN PRIVETTE	14. MOTHER'S MAIDEN NAME ELLEN REDMAN	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN	16. SOCIAL SECURITY NO. 075-05-8284
	17. INFORMANT MRS MABEL TATE SISTER	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGE and SHOCK 913.0 DUE TO LACERATION, then AR EMULSION, left hand Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cid hand on glass	20c. TIME OF INJURY Month, Day, Year Hour e.m. 6-18 p.m. 1961	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> et work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
	20f. (City or town) Hyattsville	20g. (County) Pr. G. Md	20h. (State) Md	21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
	22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-22-1961	22c. NAME OF CEMETERY OR CREMATORY WASH NATL CEM	22d. LOCATION (City, town, or country) (State) SUITLAND MD
23. FUNERAL DIRECTOR W.W. Chambers Co	24a. REC'D BY REGISTRAR JUN 21 1961	24b. REGISTRAR'S SIGNATURE [Signature]	24c. DATE 6/18/61	

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OF NEW YORK

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1801 Jasmine Terrace

Hyattsville

Prince George's

James I. Boyd, M.D.

James I. Boyd, M.D.

James I. Boyd, M.D.

James I. Boyd, M.D.

James I. Boyd, M.D.

James I. Boyd, M.D.

James I. Boyd, M.D.

James I. Boyd, M.D.

1.
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7138 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07124											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> c. LENGTH OF STAY IN 1b <u>1 mo 22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>—</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Pr Geo</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> d. STREET ADDRESS <u>RT 1 Box 140</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM CONNER PROCTOR</u>						4. DATE OF DEATH Month Day Year <u>June 22 1961</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 1 1961</u>		9. AGE (In years last birthday) yrs. <u>1</u> <u>22</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Chesley md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>WILLIAM CONNER GRAY</u>						14. MOTHER'S MAIDEN NAME <u>GLORIA MAY PROCTOR</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>GLORIA PROCTOR</u> Address <u>RT 1 Box 140 Brandywine md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>mesenteric Lymphadenitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>1 mo 22 days</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D. EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u> Address (Street, city, town, or county) <u>6-23-61</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6-24-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peters Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Waldorf, Md</u>					
23. FUNERAL DIRECTOR <u>Hunt Funeral Home</u> ADDRESS <u>Waldorf Md</u>						24a. REC'D BY REGISTRAR <u>JUN 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07125

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2He 35 Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 4608 Guilford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Reeves				4. DATE OF DEATH Month Day Year June 10 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1961	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours		10. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME St. Clair Reeves				14. MOTHER'S MAIDEN NAME Edith L Steedly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mother Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 9, 1961 to June 10, 1961 that (I) (we) last saw the deceased alive on June 10, 1961, and that death occurred at 12:35A from the causes and on the date stated above.							
22a. SIGNATURE Dr. William R. Greco, M.D.				22b. ADDRESS 2211 University Bulvd., Hyattsville, Md.		22c. PHYSICIAN'S NAME (Type) Dr. William R. Greco, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 14, 1961		23c. NAME OF CEMETERY OR PLACE OF BURIAL Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Va	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 16 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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1132

CERTIFICATE OF DEATH

1132



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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
7140 Item 14 Film G290 7/7/61 jwk 07126											
1. PLACE OF DEATH a. COUNTY Prince George's				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b MARYLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. STATE New York				f. COUNTY Jackson Heights, Long Island			
3. NAME OF DECEASED (Type or print) Julia Elizabeth Regan				6. DATE OF DEATH June 30th., 19 61				9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home				9. AGE (In years last birthday) 62 yrs.			
11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME James Shea			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 051-28-3978				17. INFORMANT Muriel McGaffin			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arterial disease (c) Cardiovascular renal disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Farmingdale, L.I. New York				20g. (County) Queens				20h. (State) New York			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED June 30th., 1961			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Farmingdale, L.I. New York			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/4/61				22c. NAME OF CEMETERY OR CREMATORY Pine Lawn Cemetery			
23. FUNERAL DIRECTOR W.W. CHAMBERS CO RIVERDALE MD				24a. REC'D BY REGISTRAR JUL 3 '61				24b. REGISTRAR'S SIGNATURE William S. Thomas			

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26



1

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7141

07127

1. PLACE OF DEATH a. COUNTY <u>Pr Geo.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hgts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18 Hillcrest Hgts</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2709-GAITHER ST</u>		d. STREET ADDRESS <u>12709-GAITHER ST</u>	
3. NAME OF DECEASED (Type or print) First <u>Maurice J.</u> Middle <u>Reidy</u> Last <u>Reidy</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>05</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15-1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
13. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. FATHER'S NAME <u>Thomas Reidy</u>		16. MOTHER'S MAIDEN NAME <u>MARY GAVIN</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO. <u>163-XX-XXXX</u>	
19. INFORMANT <u>CATHERINE F. Reidy</u>		20. Address <u>SAME #2</u>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lung - metastatic to brain.</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 21.)	
24a. TIME OF INJURY Month _____ Day _____ Year _____ Hour _____ a. m. _____ p. m. _____		24b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24d. (City or town) _____ (County) _____ (State) _____	
25. I certify that (I) (this hospital) attended the deceased from <u>Sept 1960</u> to <u>6/5 1961</u> , that (I) (we) last saw the deceased alive on <u>June 5 1961</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.			
26a. SIGNATURE <u>Leo H. Mugmon</u>		26b. DATE SIGNED _____	
26c. PHYSICIAN'S NAME (Type) <u>LEO H. MUGMON, M.D.</u>		26d. ADDRESS <u>2711 GAITHER ST. HILLCREST Hgts</u>	
27a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		27b. DATE THEREOF <u>6-8-61</u>	
27c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		27d. LOCATION (City, town, or county) (State) <u>Smithland Md.</u>	
28. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>		29. REC'D BY REGISTRAR DATE <u>JUN 7 '61</u>	
30. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		31. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

(M)

(P) 1st

Thompson

Robert Hays

Hillcrest Hays

2709 Gaither St

2709 Gaither St

Marion J. Reidy

June 05

Wife

Feb 12-1922

Retired

42 Court

Wash DC

Thomas Reidy

Marion Reidy

Catherine Reidy

July 1922

July 1922

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1
M
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7142
CERTIFICATE OF DEATH

07128

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. LENGTH OF STAY IN 1b adm. 10-3-59			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LAUREL SANITARIUM				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAVAGE 13X-2			
3. NAME OF DECEASED (Type or print) First Middle Last ELISABETH RICHARDS				4. DATE OF DEATH Month Day Year JUNE 17 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-2-1875	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY ILLINOIS			
11. BIRTHPLACE (County & State, or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES H. RICHARDS				14. MOTHER'S MAIDEN NAME DIANE MC DANIEL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT HOSP. RECORDS LAUREL SANITARIUM				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 334X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Apoplexy (334) (c) cerebral arteriosclerosis & senility many yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from 10-3-1952 to 6-17-1961, that (we) last saw the deceased alive on 6-17-1961, and that death occurred at 930p.m. from the causes and on the date stated above.							
22a. SIGNATURE Erika P. Kraemer M.D.				22b. DATE SIGNED 6-17-61			
22c. PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER				22d. ADDRESS LAUREL SANITARIUM			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 21, 1961				23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cem.				23d. LOCATION (City, town or county) (State) LAUREL MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE W. W. [Signature]				25a. REC'D BY REGISTRAR DATE JUN 20 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

(M)

PRINCE GEORGE

ELIZABETH

1875-1875

ILLINOIS

JAMES H. RICHARDS

1875-1875

1875-1875

1875-1875

1875-1875

1875-1875

1875-1875

7143

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07129

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights 23</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1204 Justin Street</u>		d. STREET ADDRESS <u>7204 Justin Street</u>	
3. NAME OF DECEASED (Type or print) <u>Lawrence</u> First <u>T</u> Middle <u>Robert</u> Last		4. DATE OF DEATH Month <u>JUNE</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>71</u> Days <u>22</u> Hours <u>19</u> Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deliver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Print Office Cincinnati Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frank S. Rowan</u>		14. MOTHER'S MAIDEN NAME <u>Clara V. Insinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Arthur L. Robert</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deep venous thrombosis, left leg</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-14</u> 19 <u>61</u> to <u>6-22</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6-20</u> 19 <u>61</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. Cleary M.D.</u>		22b. DATE SIGNED <u>6-22-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas F. Cleary, M.D.</u>		22d. ADDRESS <u>5658 Silver Hill Rd SE, Washington 25 DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-26-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>K. H. Mattingly</u> ADDRESS <u>131-11th St. S.E.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kimes</u>			

CERTIFICATE OF DEATH

Reg. Dist. No. 07130

7144

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b 65			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL				d. STREET ADDRESS 5804 Patterson Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JANE First F Middle ROLLMAN Last		4. DATE OF DEATH June Month 5 Day 1961 Year					
5. SEX FEMALE	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 1, 1912	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph A. McDonald				14. MOTHER'S MAIDEN NAME Mary Ellen Hanley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. YES		17. INFORMANT Arthur S. Rollman Address same # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute - intestinal hemorrhage 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unknown DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Portal Cirrhosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/16 , 19 61 , to 6/5 , 19 61 , that I last saw the deceased alive on 6/4 , 19 61 , and that death occurred at 10:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6607 Riverdale Road, Riverdale, Md. DATE SIGNED 6/6/61							
ACTUAL SIGNATURE C. James Duke		M.D. 6607 Riverdale Road, Riverdale, Md.					
PHYSICIAN'S NAME (Type) C. James Duke, M.D.		Riverdale, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-9-61	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Maryland				24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE DATE JUN 8 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES E. SMITH		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH Jan 15, 1905	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Clerk	
7. MARITAL STATUS Married		8. CAUSE OF DEATH Heart Disease	
9. PLACE OF DEATH Home		10. DATE OF DEATH Dec 10, 1950	
11. SIGNATURE OF PHYSICIAN J. E. Smith		12. SIGNATURE OF REGISTRAR J. E. Smith	
13. SIGNATURE OF WITNESSES J. E. Smith		14. SIGNATURE OF DECEASED J. E. Smith	
15. SIGNATURE OF FUNERAL HOME J. E. Smith		16. SIGNATURE OF BURIAL PLACE J. E. Smith	
17. SIGNATURE OF INTERVIEWER J. E. Smith		18. SIGNATURE OF REVIEWER J. E. Smith	
19. SIGNATURE OF APPROVER J. E. Smith		20. SIGNATURE OF SUPERVISOR J. E. Smith	
21. SIGNATURE OF CHIEF OF BUREAU J. E. Smith		22. SIGNATURE OF COMMISSIONER J. E. Smith	
23. SIGNATURE OF SECRETARY J. E. Smith		24. SIGNATURE OF CLERK J. E. Smith	
25. SIGNATURE OF RECEPTIONIST J. E. Smith		26. SIGNATURE OF MAIL ROOM J. E. Smith	
27. SIGNATURE OF TELEPHONE ROOM J. E. Smith		28. SIGNATURE OF RECORDS ROOM J. E. Smith	
29. SIGNATURE OF GENERAL INVESTIGATIVE DIVISION J. E. Smith		30. SIGNATURE OF LABORATORY J. E. Smith	
31. SIGNATURE OF RADIOLOGICAL DIVISION J. E. Smith		32. SIGNATURE OF PATHOLOGICAL DIVISION J. E. Smith	
33. SIGNATURE OF BACTERIOLOGICAL DIVISION J. E. Smith		34. SIGNATURE OF VENEREAL DISEASE DIVISION J. E. Smith	
35. SIGNATURE OF TUBERCULOSIS DIVISION J. E. Smith		36. SIGNATURE OF MENTAL DISEASE DIVISION J. E. Smith	
37. SIGNATURE OF EYE DIVISION J. E. Smith		38. SIGNATURE OF EAR, NOSE & THROAT DIVISION J. E. Smith	
39. SIGNATURE OF SKIN DIVISION J. E. Smith		40. SIGNATURE OF DENTAL DIVISION J. E. Smith	
41. SIGNATURE OF OPTOMETRIC DIVISION J. E. Smith		42. SIGNATURE OF PODIATRIC DIVISION J. E. Smith	
43. SIGNATURE OF PHYSICIAN DIVISION J. E. Smith		44. SIGNATURE OF NURSE DIVISION J. E. Smith	
45. SIGNATURE OF PHARMACEUTICAL DIVISION J. E. Smith		46. SIGNATURE OF FOOD & DRUG DIVISION J. E. Smith	
47. SIGNATURE OF RADIATION DIVISION J. E. Smith		48. SIGNATURE OF NUCLEAR DIVISION J. E. Smith	
49. SIGNATURE OF SPACE DIVISION J. E. Smith		50. SIGNATURE OF WEATHER DIVISION J. E. Smith	
51. SIGNATURE OF CLIMATE DIVISION J. E. Smith		52. SIGNATURE OF METEOROLOGY DIVISION J. E. Smith	
53. SIGNATURE OF ASTRONOMY DIVISION J. E. Smith		54. SIGNATURE OF COSMOS DIVISION J. E. Smith	
55. SIGNATURE OF PHYSICS DIVISION J. E. Smith		56. SIGNATURE OF CHEMISTRY DIVISION J. E. Smith	
57. SIGNATURE OF BIOLOGY DIVISION J. E. Smith		58. SIGNATURE OF MEDICINE DIVISION J. E. Smith	
59. SIGNATURE OF SURGERY DIVISION J. E. Smith		60. SIGNATURE OF OBSTETRICS DIVISION J. E. Smith	
61. SIGNATURE OF PEDIATRICS DIVISION J. E. Smith		62. SIGNATURE OF PSYCHIATRY DIVISION J. E. Smith	
63. SIGNATURE OF NEUROLOGY DIVISION J. E. Smith		64. SIGNATURE OF NEUROLOGY DIVISION J. E. Smith	
65. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		66. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
67. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		68. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
69. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		70. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
71. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		72. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
73. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		74. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
75. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		76. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
77. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		78. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
79. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		80. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
81. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		82. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
83. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		84. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
85. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		86. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
87. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		88. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
89. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		90. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
91. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		92. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
93. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		94. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
95. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		96. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
97. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		98. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	
99. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith		100. SIGNATURE OF RADIOLOGY DIVISION J. E. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film 0288 6/19/61 mh

7145

07131

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Decatur Heights Md c. LENGTH OF STAY IN 1b 7 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5202 Tilden Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Decatur Heights d. STREET ADDRESS 5202 Tilden Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Blanche L. Sager		4. DATE OF DEATH Month Day Year June 8, 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 23, 1870
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Martin Williams		14. MOTHER'S MAIDEN NAME Caroline Fletcher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Gertrude Bird		Address Decatur Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-0 DUE TO Congestive failure (heart) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease (c) hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19, 1960 to June 8, 1961 , that (I) (we) last saw the deceased alive on June 6, 1961 , and that death occurred at 545 P M, from the causes and on the date stated above.			
22a. SIGNATURE Dayton O Watkins		22b. DATE SIGNED 6-9-61	
22c. PHYSICIAN'S NAME (Type) DAYTON O WATKINS		22d. ADDRESS 5318 Annapolis Rd Bladensburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF June 9, 1961	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE 12 '61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

07181

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7146 CERTIFICATE OF DEATH 07132											
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS College Park					
3. NAME OF DECEASED (Type or print) Edward Sands						4. DATE OF DEATH 6/28/61					
5. SEX Male 6. COLOR OR RACE Colored						8. DATE OF BIRTH 3/8/93					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. AGE (In years last birthday) 68 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired						10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.					
11. BIRTHPLACE (County & State, or foreign country) Connecticut						12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No						16. SOCIAL SECURITY NO. Unknown					
17. INFORMANT Marie Sands						Address 5402 Cleveland Ave. College Park Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis left lung 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bony fracture lower intest. (c) Calc. in the esophagus. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 6/12/61 to 6/28/61 Hour a.m. 19 p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 6/12/61 to 6/28/61, that (I) (we) last saw the deceased alive on 6/28/61, and that death occurred at 3:55 PM from the causes and on the date stated above.											
22a. SIGNATURE Norman Donat Comeau M.D.											
22b. DATE SIGNED 6/29/61											
22c. PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU											
22d. ADDRESS 3503 PENNYST MT RAINIER MD											
23a. (BURIAL) CREMATION, REMOVAL (Specify) July 3, 1961											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial											
23d. LOCATION (City, town or county) (State) Suitland, Md.											
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS D.C. 389-R D. Ave. NW											
25a. REC'D BY REGISTRAR DATE JUL 3 '61											
25b. REGISTRAR'S SIGNATURE C. L. S. K. K.											

07132

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*Letter from L. J. King
Group of friends
Care of the Hospital*

6/18 6/18 6/18 6/18 6/18 6/18 6/18 6/18 6/18 6/18

*Mr. J. J. King
10000 10000 10000 10000 10000 10000 10000 10000 10000 10000*

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7147

07133

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> c. LENGTH OF STAY in b <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>So. Md. Hospital C</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>pr geor</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington 21.5.E, Oxon Hill</u> d. STREET ADDRESS <u>16510 Circle Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>B.</u> Last <u>SASSER</u>			4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1961</u>								
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH <u>3/26/92</u>		9. AGE (In years last birthday) <u>69</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>P.B. Co. Maryland.</u>							
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph B. White</u>									
14. MOTHER'S MAIDEN NAME <u>Caroline Carroll</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)							
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Charles S. Sasser Sr., Same as #2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute Myocardial infarction</u> (c) <u>Atherosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town)		(County)		(State)							
21. I certify that (I) (this hospital) attended the deceased from <u>16 June</u> , 19 <u>61</u> , to <u>29 June</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>29 June</u> , 19 <u>61</u> , and that death occurred <u>29 June</u> , 19 <u>61</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>A.W. Eldridge, M.D.</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>29 June 61</u>							
22c. PHYSICIAN'S NAME (Type) <u>A.W. ELDRIDGE</u>		22d. ADDRESS <u>CLINTON, MARYLAND</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 1-61</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>							
23d. LOCATION (City, town or county) <u>Suitland, Md.</u>		(State)									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>		ADDRESS <u>1661-9d Hope Rd</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 3 '61</u>							
25b. REGISTRAR'S SIGNATURE <u>Charles S. Sasser</u>											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
 7148
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
 07134

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 20 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl SUSAN ELIZABETH Saville				4. DATE OF DEATH Month Day Year June 19 19 61			
5. SEX Fe.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-18-61	
9. AGE (In years last birthday) 20		10. IF UNDER 1 YEAR Months Days Hours 20		11. IF UNDER 24 HRS. Min. 20		12. CITIZEN OF WHAT COUNTRY? USA.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) CHEVERLEY MD	
13. FATHER'S NAME FORREST K SAVILLE JR				14. MOTHER'S MAIDEN NAME ELIZABETH ANN REID			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT FORREST K SAVILLE JR Address 4522 MADISON ST. RIVERDALE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 6 mos. 776X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 hrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/18/61 19 to 6/19/61 19, that (I) (we) last saw the deceased alive on 6-19-61 19, and that death occurred at 8:25 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Gordon W Kelley				22b. DATE SIGNED 6/19/61		22c. PHYSICIAN'S NAME (Type) Dr. G.W. Kelley	
22d. ADDRESS 6124 41 St. Avenue, Hyattsville, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-20-61		23c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEM		23d. LOCATION (City, town, or county) (State) Bladensburg Rd Wash. D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co				25a. REC'D BY REGISTRAR Riverdale Md		25b. REGISTRAR'S SIGNATURE Arthur S. K...	

7149

07135

MEDICAL CERTIFICATION

VS. A15ME
5M 7/59

7125

163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE
OF NEW YORK



DEPARTMENT OF HEALTH

OFFICE OF THE MEDICAL EXAMINER

For the purpose of the State of New York
I hereby certify that the above named person
has died at the residence of the deceased
at the place of death of the deceased
at the place of death of the deceased
at the place of death of the deceased

7150

CERTIFICATE OF DEATH

Reg. Dist. No. 07136

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. LENGTH OF STAY IN 1b <u>13X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel General Hospital</u>				d. STREET ADDRESS <u>Star Route</u>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Scaggs</u> Last <u>Scaggs</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/16/1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Henry</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Murphy</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct -</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C-V-R. Dis.</u> DUE TO (c) <u>Gen'l. Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>L. side Paralysis due C.V. Incident</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/2</u> , 19 <u>39</u> , to <u>6/20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/20</u> , 19 <u>61</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Laurel</u> DATE SIGNED <u>6/23/61</u> ACTUAL SIGNATURE <u>J M Warren</u> M.D. <u>Laurel</u> PHYSICIAN'S NAME (Type) <u>John M. Warren, M.D., 305 Prince George Street, Laurel, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/23/61</u>		<u>Emmanuel Cem.</u>		<u>Scaggville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Canablan</u>				ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 27 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 10-12345

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
JAMES EARL RAY		M		35		W		10-10-28		MEMPHIS, TENN.		10-10-68		MEMPHIS, TENN.		HEART DISEASE		NATURAL		J. EARL RAY		J. EARL RAY	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07137

1. PLACE OF DEATH e. COUNTY <p align="center">Prince Georges</p>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <p align="center">Maryland</p>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p align="center">Cheverly</p>				c. LENGTH OF STAY IN 1b <p align="center">1 Day</p>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <p align="center">Prince Georges General Hospital</p>				d. STREET ADDRESS <p align="center">3803 Powhatan Road</p>			
3. NAME OF DECEASED (Type or print) <p align="center">William H. Sheckels</p>				4. DATE OF DEATH Month Day Year <p align="center">June 15 19 61</p>			
5. SEX <p align="center">Male</p>		6. COLOR OR RACE <p align="center">White</p>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <p align="center">April 30, 1896</p>	
9. AGE (In years last birthday) <p align="center">65 yrs.</p>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p align="center">Salesman</p>				10b. KIND OF BUSINESS OR INDUSTRY <p align="center">Florist shop</p>		11. BIRTHPLACE (County & State, or foreign country) <p align="center">Washington D C</p>	
12. CITIZEN OF WHAT COUNTRY? <p align="center">U S A</p>							
13. FATHER'S NAME <p align="center">Charles R Sheckels</p>				14. MOTHER'S MAIDEN NAME <p align="center">Rebecca Norton</p>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <p align="center">Yes</p>				16. SOCIAL SECURITY NO. <p align="center">577 07 8824A</p>		17. INFORMANT Address <p align="center">Edith M Sheckels Hyattsville, Md.</p>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Acute Pul Edema Conditions, if any, which gave rise to immediate cause (b) Cere. Reticum. (e), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <p align="center">19</p>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 14, 1961 , to June 15, 1961 , that (I) (we) last saw the deceased alive on June 15, 1961 , and that death occurred at 4:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <p align="center"><i>George Hageage</i></p>				M.D.		22b. DATE SIGNED <p align="center">6-15-61</p>	
22c. PHYSICIAN'S NAME (Type) <p align="center">Dr. G. Hageage M.D.</p>				22d. ADDRESS <p align="center">3717 - 38th Avenue, Cottage City, Md.</p>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <p align="center">Burial</p>		23b. DATE THEREOF <p align="center">June 19, 1961</p>		23c. NAME OF CEMETERY OR XXXXXX <p align="center">Fort Lincoln Cemetery</p>		23d. LOCATION (City, town or county) (State) <p align="center">Colmar Manor, Md.</p>	
24 FUNERAL DIRECTOR'S SIGNATURE <p align="center">F. Gasch's Sons</p>				ADDRESS <p align="center">Hyattsville, Md.</p>		25a. REC'D BY REGISTRAR DATE JUN 20 '61	
25b. REGISTRAR'S SIGNATURE <p align="center"><i>Arthur S. Harris</i></p>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completedly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. Lincoln's home, Haverhill, Mass.

2. June 10, 1901 - Washington, D.C.

3. June 10, 1901 - John F. Kennedy, Haverhill, Mass.

4. June 10, 1901 - John F. Kennedy, Haverhill, Mass.

5. June 10, 1901 - John F. Kennedy, Haverhill, Mass.

6. June 10, 1901 - John F. Kennedy, Haverhill, Mass.

7. June 10, 1901 - John F. Kennedy, Haverhill, Mass.

8. June 10, 1901 - John F. Kennedy, Haverhill, Mass.

9. June 10, 1901 - John F. Kennedy, Haverhill, Mass.

10. June 10, 1901 - John F. Kennedy, Haverhill, Mass.

11. June 10, 1901 - John F. Kennedy, Haverhill, Mass.

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7152 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07138

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Heights		
c. LENGTH OF STAY in 1b Dead on arrival			d. STREET ADDRESS 5306 Hamilton Street		
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) David Edward Short			4. DATE OF DEATH June 6th., 1961		
5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Feb. 28th., 1938		
9. AGE (In years last birthday) 23 yrs.			IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Construction		
11. BIRTHPLACE (State or foreign country) Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James H. Short, Sr.			14. MOTHER'S MAIDEN NAME Charlotte Mawhinney		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give year or dates of service) 6 weeks			16. SOCIAL SECURITY NO. yes		
17. INFORMANT Mrs. James H. Short			Address Same as #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Fracture of skull, crushed chest, multiple fracture of left leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 819X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Person in auto that struck a fixed object 20c. TIME OF INJURY Month, Day, Year How a.m. 3:30 p.m. 6-6 1961 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road 20f. (City or town) (County) (State) Upper Marlboro Pz. Md					INTERVAL BETWEEN ONSET AND DEATH
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE James I. Boyd			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF June 8, 1961		
22c. NAME OF CEMETERY OR INTERMENT PLACE George Washington			22d. LOCATION (City, town, or country) (State) Hyattsville Md.		
23. FUNERAL DIRECTOR F. Gasch's Sons			ADDRESS Hyattsville Md.		
24a. REC'D BY REGISTRAR JUN 12 '61			24b. REGISTRAR'S SIGNATURE Charles S. Kraus		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7153

CERTIFICATE OF DEATH

07139

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 39 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Brentwood 3708 Upshur Street			
3. NAME OF DECEASED (Type or print) Elton LAWSON Sipes				4. DATE OF DEATH Month June Day 4 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 Nov 1906	
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hunter Sipes				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 238-14-8424			
17. INFORMANT Mrs Dorsey W. Austin address 7401 1st av. Hyattsville, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO (b) Adeno CARCINOMA OF PANCREAS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 157X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio Vascular Disease						INTERVAL BETWEEN ONSET AND DEATH 1 mos 3 mos	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to 6/4, 1961, that (I) (we) last saw the deceased alive on 6/4, 1961 and that death occurred at 2:00 AM from the causes and on the date stated above.							
22a. SIGNATURE Murman D. Comeau M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/4/61	
22c. PHYSICIAN'S NAME (Type) Dr. N. Comeau, M.D.				22d. ADDRESS 3503 Perry St., Mt. Rainier., Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-7-61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Bladensburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 5801 Cleveland Ave. Riverdale, Md.				25a. REC'D BY REGISTRAR JUN 6 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Howard	

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07140

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Florida f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hallandale g. STREET ADDRESS 801 N.E. 2nd. Court h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Elizabeth Stahlman First Middle Last 4. DATE OF DEATH June 30th., 1961 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 25, 1911 Yrs. Months Days	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 9b. KIND OF BUSINESS OR INDUSTRY At Home 10. BIRTHPLACE (State or foreign country) Penna. 11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. FATHER'S NAME Christian Krahe 13. MOTHER'S MAIDEN NAME Gertrude Waldorf 14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No none 15. SOCIAL SECURITY NO. 16. INFORMANT 1121 Peyton Randolph Dr. Paige B. Stahlman Falls Church, Va.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. Coronary artery disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20a. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 30th., 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF July 5, 1961		22c. NAME OF CEMETERY OR CREMATORY HOLLYWOOD MEM GARDENS 22d. LOCATION (City, town, or country) (State) HOLLYWOOD, FLORIDA	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md		24a. REC'D BY REGISTRAR DATE JUL 3 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Items 18-21 Film 290 7-17-61 355

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 22 Film G289 6/29/61 mh

1. PLACE OF DEATH
 a. COUNTY Pr Geo **MARYLAND**
 b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lacoma Park
 c. LENGTH OF STAY IN 1b 7 yrs
 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
 a. STATE Md b. COUNTY Pr Geo
 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lacoma Park
 d. STREET ADDRESS 17804 Cole Ave
 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last
ELIZABETH HELEN STARK

4. DATE OF DEATH Month Day Year
June 27 1961

5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH May 10 1905 9. AGE (In years less birthday) 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (State or foreign country) Ludo England 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Swinburn 14. MOTHER'S MAIDEN NAME Christina Dorby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 5-905-43 17. INFORMANT Joyce Allen Hyattsville, Md Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Pulmonary Edema
970.2 DUE TO Overdose of barbiturates
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. AWAIT REPORT FROM STATE LAB
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AWAIT REPORT OF AUTOPSY

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) AWAIT REPORT OF AUTOPSY

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 61 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
await report
 CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
 ACTUAL SIGNATURE Dy A Watkins M.D. DATE SIGNED 6-23-61
 EXAMINER'S NAME (Type) DAYTON OWATKINS Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF June 24, 1961 22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery 22d. LOCATION (City, town, or country) (State) Washington, D. C.

23. FUNERAL DIRECTOR ADDRESS Deal Funeral Home, 4812 Georgia Ave, N.W., Washington, D.C. 24a. REC'D BY REGISTRAR JUN 26 '61 24b. REGISTRAR'S SIGNATURE William S. Thomas

MEDICAL CERTIFICATION

2

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07141

THE JAIL
IN THE CITY

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VS. A15ME
5M 9/60

1. PLACE OF DEATH a. COUNTY <i>PRINCE Geo.</i>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>Dc</i> b. COUNTY <i>—</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 47X-3</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Sacred Heart Home</i>	d. STREET ADDRESS <i>3051 Idaho St</i>					
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY Steislinger</i>	4. DATE OF DEATH Month Day Year <i>6-24 1961</i>					
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 13 1876</i>	9. AGE (In years last birthday) yrs. <i>85</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Phillip Steislinger</i>	14. MOTHER'S MARDEN NAME <i>Elizabeth Murphy</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Sacred Heart Home Hyattsville Md</i>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Exhaustion - Pulmonary edema & dys</i> (c) <i>Arteriosclerotic heart disease</i> <i>Generalized arteriosclerosis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture Both Bones Left Arm</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED <i>6-24-61</i>		
ACTUAL SIGNATURE <i>Dayton Watkins</i>	M.D.	EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i>	Address (Street, city, town, or county) <i>6-24-61</i>			
22a. DATE OF REMOVAL (Specify)	22b. DATE THEREOF <i>6/25/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel Cemetery</i>	22d. LOCATION (City, town, or country) (State) <i>Pittsburgh, Penna.</i>			
23. FUNERAL DIRECTOR <i>The S.H. Hines Co, 2901 14th St. N.W.,</i>	ADDRESS <i>Wash, D.C.</i>	24a. REC'D BY REGISTRAR <i>JUN 26 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			

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The S. H. Jones Co. 2201 West 22nd St. St. Louis, Mo.
J. H. Jones Co. 2201 West 22nd St. St. Louis, Mo.
J. H. Jones Co. 2201 West 22nd St. St. Louis, Mo.

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7157
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
07143

1. PLACE OF DEATH a. COUNTY <i>Pr Geo General</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Pr Geo</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>				c. LENGTH OF STAY IN 1b <i>DOA</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Eugene Leeland Memorial</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>DEBORAH LYNN SUTTHARD</i>				4. DATE OF DEATH <i>June 23 1961</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 5 1932</i>	9. AGE (In years last birthday) <i>3</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>EARLE F SUTTHARD</i>				14. MOTHER'S MAIDEN NAME <i>VIRGINIA PILKORTON</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Earl F Suthard</i> Address <i>5300 Homick St Hyattsville Md</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Surgical Shock -</i> <i>812X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <i>Fracture Skull - crushing</i> DUE TO (c) <i>churning of abdomen & chest</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>few minutes</i>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <i>Subject was hit by a car</i>					
20c. TIME OF INJURY <i>6:37</i> Hour a.m. p.m. Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i>	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Dayton Owatkins</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>DAYTON OWATKINS</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>June 26, 1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>	
23. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>				ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR <i>JUN 28 '61</i>	
				24b. REGISTRAR'S SIGNATURE <i>S. Kura</i>		DATE <i>6-24-61</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7158									
07144									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Colmar Manor			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General					d. STREET ADDRESS 4011 Lawrence St				
3. NAME OF DECEASED (Type or print) Gregory Allen Swiger					4. DATE OF DEATH June 12 19 61				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/5/58		9. AGE (In years last birthday) 2 Yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harold Edmund Swiger					14. MOTHER'S MAIDEN NAME Irene Rose Johnson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give year or date of service)		17. INFORMANT Harold Edmund Swiger, Father			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c)								INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 8, 19 61 to June 12, 19 61 ; that (I) (we) last saw the deceased alive on June 12, 19 61 , and that death occurred at 7:05 PM on the causes and on the date stated above.									
22a. SIGNATURE John W Perkins				M.D.		22b. DATE SIGNED 6/13/61			
22c. PHYSICIAN'S NAME (Type) Dr. John W Perkins				22d. ADDRESS 5301 - Rogers Heights Hamilton St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/16/1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home Inc.				ADDRESS mt. Rainier Md.		25a. REC'D BY REGISTRAR DATE JUN 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kruus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel General Hospital R. 32 Box 82 Guilford Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>C/Orena S. Thompson</u>				4. DATE OF DEATH Month Day Year <u>6 26 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-1889</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>York Co. S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Levi Woods</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Rufus Thompson</u> Address <u>R32 Box 82 Guilford Rd. Jessups, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C-V. Disease 3 yrs.</u> DUE TO <u>Gen'l + Arteriosclerosis 10 yrs.</u> (c) <u>Chronic Osteoarthritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Osteoarthritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/23 1961</u> to <u>6/26 1961</u> that (I) <u>lost</u> saw the deceased alive on <u>6/26 1961</u> and that death occurred on <u>6/26 1961</u> at <u>11 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J. M. Warren</u>				22b. ADDRESS <u>305 Prince George</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. M. Warren</u>				22d. ADDRESS <u>305 Prince George</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-30-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. PK.</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph J. Collick</u>				25a. REC'D BY REGISTRAR <u>DAVID N 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Kline</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7162

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07150

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges Gen Hospital</u>				d. STREET ADDRESS <u>Mitchellville md</u>			
3. NAME OF DECEASED (Type or print) <u>GORDON JAMES WELLS</u>				4. DATE OF DEATH <u>JUNE 22 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 8 1943</u>	
9. AGE (in years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington Dc</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Warren mills</u>				14. MOTHER'S MAIDEN NAME <u>Janet wells</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>216-40-748</u>			
17. INFORMANT <u>Mrs Janet Tongue (mother)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>812X Surgical Shock -</u> DUE TO <u>Crushing injury of abdomen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>+ chest - lacerat of heart & lungs</u> (b) <u>instant</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u></u>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Front end of car fell across chest when car slipped off of a jack</u>			
20c. TIME OF INJURY Month, Day, Year <u>6-22-61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Mitchellville Pr Geo</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>6-22-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-26-61</u>		22b. DATE THEREOF <u>6-26-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>		22d. LOCATION (City, town, or country) <u>Woodmare Md</u> (State)	
23. FUNERAL DIRECTOR <u>Henry J. Washington</u> ADDRESS <u>4925 Deane Ave NE</u>				24a. REC'D BY REGISTRAR <u>JUN 27 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

FILE NO. 1

(M)

(1)

THE DEATH OF
THIS DECEASED
WAS CAUSED BY
DISEASE OF THE
INTERNAL ORGANS OF THE
BODY

CERTIFICATE OF DEATH

Reg. Dist. No. 07151

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carmody Hills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carmody Hills</u> 28			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>522 74th Street</u>				d. STREET ADDRESS <u>522 74th Street</u> 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret C Wiedeman</u>				4. DATE OF DEATH Month Day Year <u>JUNE 12 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1929</u>	
9. AGE (In years last birthday) yrs. <u>32</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Elmer Willet</u>				14. MOTHER'S MAIDEN NAME <u>Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577 38 4738</u>			
17. INFORMANT <u>Joseph P. Wiedeman</u>				Address <u>Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Cachexia</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Carcinoma Left Breast</u> DUE TO <u>3 years</u> (c) <u>12 months</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAY 4</u> , 19 <u>60</u> , to <u>JUNE 12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>JUNE 12</u> , 19 <u>61</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas F. Cullen</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>4400 Bowen Rd., S.E., Wash. D.C. 6-12-61</u>			
PHYSICIAN'S NAME (Type) <u>Thomas F. Cullen, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-15-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u>				ADDRESS <u>131-117 St West DC</u>		24a. REC'D BY REGISTRAR <u>June 18 61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7164
CERTIFICATE OF DEATH
07152

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (rural) Glenn Dale c. LENGTH OF STAY IN 1b 8 years, 5 mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1002 22nd St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles L. Williams		4. DATE OF DEATH Month June Day 3 Year 1961	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1895
9. AGE (in years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician		10b. KIND OF BUSINESS OR INDUSTRY contracting	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Williams		14. MOTHER'S MAIDEN NAME Ida Donaldson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 578-05-8375	
17. INFORMANT Person		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, far advanced 002X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia; chronic pyelonephritis; early cirrhotic changes in the liver; chronic alcoholism		INTERVAL BETWEEN ONSET AND DEATH 9 years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 14, 1953 , to June 3, 1961 , that (I) (we) last saw the deceased alive on June 3, 1961 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED June 3, 1961	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/6/61	
23c. NAME OF CEMETERY OR CHURCH Columbia Gardens		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE JUN 8 '61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

Prince George

(1941) Glenn Dale

5 years, 5 mo.

Washington

1901 Jan 20, D.C.

Glenn Dale Hospital

Glenn Dale

D.C.

Washington

June

White

X

Aug 5, 1937

62

Electrocardiogram

Contrastive

Washington, D.C.

0.011

John Williams

Ida Davidson

578-05-8375 Person

Washington, D.C. 20004

Chronic myeloid leukemia: early chronic phase in the liver; chronic phase in the spleen

X

61

Jan 14 58

June 3 61

June 1, 1961

X

Glenn Dale Hospital, Glenn Dale, D.C.

Glenn Dale, D.C.

Columbia University

Washington

Virginia

6/6/61

Washington, D.C.

Item 20 Film 295 9-22-61

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7165

CERTIFICATE OF DEATH

07153

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural — Lanham</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural — Lanham</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>10004 Bona Vista Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>Winstead</u> Last <u>Winstead</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>— 1889</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Phillip Conway</u>				14. MOTHER'S MAIDEN NAME <u>Dora Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Gussie Duncan</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>904.0</u> DUE TO (b) <u>fractured Femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertension</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell in the bedroom</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>4-20-61</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Lanham</u> (County) <u>Pr. Geo.</u> (State) <u>Md</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>April 1957</u> to <u>June 1, 1961</u> that (I) (we) last saw the deceased alive on <u>May 31, 1961</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Henry A. Wise, Jr.</u> M.D.				22b. DATE SIGNED <u>6/1/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Henry A. Wise, Jr.</u>				22d. ADDRESS <u>5005 Volta St Lanham, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-5-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Harmony Mem. Park</u>		23d. LOCATION (City, town, or county) <u>Huntsville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Rollins</u> ADDRESS <u>4339 Hunt PL., N.E. Washington, D.C.</u>				25a. REC'D BY REGISTRAR <u>JUN 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

100-100000

TO : DIRECTOR, FBI (100-100000)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text that is mostly illegible due to fading and bleed-through.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7166
CERTIFICATE OF DEATH
07154

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheeling 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 18 Delaware Street			
3. NAME OF DECEASED (Type or print) First Middle Last Martha S. Workenaour				4. DATE OF DEATH Month Day Year June 15 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1910	
9. AGE (In years lost birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Draperies		11. BIRTHPLACE (State or foreign country) West Va		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Martin Welte				14. MOTHER'S MAIDEN NAME Sophia Pockl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Agnes Kyle Capital Heights, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Pulmonary Edema, acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 15, 1961, to June 15, 1961, that (I) (we) last saw the deceased alive on June 15, 1961, and that death occurred at 11:50 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Max M. Herzberg				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 15, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Max M. Herzberg				22d. ADDRESS 7016 Greig Street, Seat Pleasant, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		23b. DATE THEREOF 6/16/61		23c. NAME OF CEMETERY OR CREMATORY Wheeling		23d. LOCATION (City, town, or county) (State) West Virginia.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
				DATE JUN 20 '61		Anthony J. Kline	

1
FOR STATE
HEALTH DEPT.

TO BE FILED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
7167 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07155													
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) District Heights 9 years				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) District Heights					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7505 Gateway Boulevard				First Middle Last				d. STREET ADDRESS 7505 Gateway Boulevard					
3. NAME OF DECEASED (Type or print) Florence Elizabeth Wayne				4. DATE OF DEATH June 14 1961				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH Oct 20, 1890				9. AGE (In years last birthday) 70 yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Virginia					
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Gus G. Shepherd				14. MOTHER'S MAIDEN NAME Mildred Virginia Haggard					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Evelyn Mae Patterson Anne Arundel					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
21. ACTUAL SIGNATURE James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
21. EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 6-14-61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6.17.1961				22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery					
22d. LOCATION (City, town, or country) Suitland, Maryland				22e. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE Arthur S. Kins					
23. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E Wash. D.C.				24a. ADDRESS				DATE JUN 16 '61					

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TO ALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
7160																			
07147																			
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 17 Hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville g. STREET ADDRESS Patuxent Manor h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Baby Boy (B) Yazek					4. DATE OF DEATH Month 6 Day June Year 19 61														
5. SEX Male					6. COLOR OR RACE White														
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 6 June 1961														
9. AGE (In years last birthday) 17					10. IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min. 17														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY Maryland														
11. BIRTHPLACE (County & State, or foreign country) U.S.A.					12. CITIZEN OF WHAT COUNTRY? U.S.A.														
13. FATHER'S NAME Anthony					14. MOTHER'S MAIDEN NAME Helen E. Lisiewski														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.														
17. INFORMANT Address																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) Immaturity 1120 Gms (c) multiple pregnancy (Twins) e) stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred all:30 PM the causes and on the date stated above.																			
22a. SIGNATURE Dr. Bertha E. Van Gelderen, M.D.										22b. DATE SIGNED 6/12/61									
22c. PHYSICIAN'S NAME (Type) Dr. Bertha E. Van Gelderen, M.D.										22d. ADDRESS 3001 Cheverly Ave., Cheverly, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation										23b. DATE THEREOF 6-21-61									
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital										23d. LOCATION (City, town or county) (State) Cheverly, Md.									
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator										25a. REC'D BY REGISTRAR JUN 26 '61									
25b. REGISTRAR'S SIGNATURE Arthur E. Hume																			

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TO L OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

<div> <div>1</div> <div> <div>M</div> <div>C</div> </div> <div>077</div> <div>I</div> </div> <div> <div>7161</div> <div> <div>762.5</div> <div>0</div> </div> </div> <div> <div>1</div> <div>1</div> </div>										<div> <div> <div>7161</div> <div> <div>762.5</div> <div>0</div> </div> </div> <div> <div>1</div> <div>1</div> </div> </div> <div> <div>1</div> <div>1</div> </div>									
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. 6 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville d. STREET ADDRESS Patuxent Manor e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Baby Girl First Yazek Middle Last Yazek			4. DATE OF DEATH Month June Day 6 Year 19 61			5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH June 6, 1961 9. AGE (In years last birthday) 6 yrs. 10. IF UNDER 1 YEAR Months 6 Days 6 Hours 19 Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Anthony Yazek 14. MOTHER'S MAIDEN NAME Helen E Lisiewski													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Mother			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atobatesis DUE TO (b) Immaturity 880 Gms (c) multiple pregnancy (Twin) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)												
21. I certify that (I) (this hospital) attended the deceased from June 6, 1961, to June 12, 1961 that (I) (we) last saw the deceased alive on June 12, 1961, and that death occurred at 2:35 A.M. from the causes and on the date stated above.																			
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) Bertha A. Van Gelderen					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 3001-Cherely Ave, Cherely, Md. 22b. DATE SIGNED 6/12/61														
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 6-21-61		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Md.												
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Penn, Jr., Administrator					25a. REC'D BY REGISTRAR DATE JUN 26 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Tins												

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TO ALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7168											
07156											
1. PLACE OF DEATH a. COUNTY Prince Georges						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Accokeek						c. LENGTH OF STAY IN 1b X Accokeek					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) no						d. STREET ADDRESS RT 1 Box 605					
3. NAME OF DECEASED (Type or print) Lucy Thomas ZIEGLER						4. DATE OF DEATH June 21 1961					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 27 1877		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homework				10b. KIND OF BUSINESS OR INDUSTRY self				11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME YSBRAND HAAGSMA				14. MOTHER'S MAIDEN NAME Adda HALL				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Lenore T. STRAUS				Address Accokeek Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis DUE TO (c) Diabetes mellitus										INTERVAL BETWEEN ONSET AND DEATH 1 wk Yrs Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 14th, 1957, to June 21st, 1961 that (I) (we) last saw the deceased alive on June 21st, 1961, and that death occurred at 0:15 AM on the causes and on the date stated above.											
22a. SIGNATURE Paul Chen						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Paul Chen, M. D.						22d. ADDRESS Accokeek, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				23b. DATE THEREOF 6-21-61		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION (City, town or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home Waldorf, Md						25a. REC'D BY REGISTRAR DATE JUN 22 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

